**PROCESSED AT :**
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MC-4246

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*Corporate office* : **Thyrocare Technologies Limited,** D-37/3, TTC MIDC, Turbhe, Navi Mumbai - 400 703
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# REPORT

**NAME** : XXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**PATIENTID** :

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

| TEST NAME | TECHNOLOGY | VALUE | UNITS | NORMAL RANGE |
|---|---|---|---|---|
| ARSENIC | ICP-MS | 1.09 | µg/L | < 5 |
| CADMIUM | ICP-MS | 0.27 | µg/L | < 1.5 |
| MERCURY | ICP-MS | 0.64 | µg/L | < 5 |
| LEAD | ICP-MS | 49.71 | µg/L | < 150 |
| CHROMIUM | ICP-MS | 6.08 | µg/L | < 30 |
| BARIUM | ICP-MS | 9.76 | µg/L | < 30 |
| COBALT | ICP-MS | 0.72 | µg/L | 0.10 - 1.50 |
| CAESIUM | ICP-MS | 2.85 | µg/L | < 5 |
| THALLIUM | ICP-MS | 0.06 | µg/L | < 1 |
| URANIUM | ICP-MS | 0.06 | µg/L | < 1 |
| STRONTIUM | ICP-MS | 27.06 | µg/L | 8 - 38 |
| ANTIMONY | ICP-MS | 4.36 | µg/L | 0.10 - 18 |
| TIN | ICP-MS | 0.88 | µg/L | < 2 |
| MOLYBDENUM | ICP-MS | 2.82 | µg/L | 0.70 - 4.0 |
| SILVER | ICP-MS | 1.01 | µg/L | < 4 |
| VANADIUM | ICP-MS | 0.57 | µg/L | < 0.8 |
| **BERYLLIUM** | **ICP-MS** | **0.08** | **µg/L** | **0.10 - 0.80** |
| BISMUTH | ICP-MS | 0.45 | µg/L | 0.10 - 0.80 |
| SELENIUM | ICP-MS | 108.4 | µg/L | 60 - 340 |
| ALUMINIUM | ICP-MS | 22.56 | µg/L | < 30 |
| NICKEL | ICP-MS | 9.87 | µg/L | < 15 |
| MANGANESE | ICP-MS | 13.5 | µg/L | 7.10 - 20 |

**Please correlate with clinical conditions.**

**Method :**

ICP - MASS SPECTROMETRY
Note:Reference range has been obtained after considering 95% population as cutoff.

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
**Sample Received on (SRT)** : Sample receiving time at Lab
**Report Released on (RRT)** : Report release time
**Sample Type** : EDTA
**Labcode** :
**Barcode** :

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REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| **HbA1c - (HPLC)** | | | |
| | **H.P.L.C** | **5.8** | **%** |

**Reference Range :**

| Reference Range: As per ADA Guidelines | Guidance For Known Diabetics |
|---|---|
| Below 5.7% : Normal<br>5.7% - 6.4% : Prediabetic<br>>=6.5% : Diabetic | Below 6.5% : Good Control<br>6.5% - 7% : Fair Control<br>7.0% - 8% : Unsatisfactory Control<br>>8% : Poor Control |

**Method :** Fully Automated H.P.L.C method

| | | | |
|---|---|---|---|
| **AVERAGE BLOOD GLUCOSE (ABG)** | CALCULATED | 120 | mg/dL |

**Reference Range :**

| |
|---|
| 90 - 120 mg/dl : Good Control<br>121 - 150 mg/dl : Fair Control<br>151 - 180 mg/dl : Unsatisfactory Control<br>> 180 mg/dl : Poor Control |

**Method :** Derived from HBA1c values

**Please correlate with clinical conditions.**

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**TEST ASKED** : AAROGYAM 1.7
**PATIENTID** :

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

| TEST NAME | VALUE | UNITS | REFERENCE RANGE |
|---|---|---|---|
| TOTAL LEUCOCYTES COUNT (WBC) | 6.48 | X 10³ / µL | 4.0 - 10.0 |
| NEUTROPHILS | 61.5 | % | 40-80 |
| LYMPHOCYTE PERCENTAGE | 31.8 | % | 20-40 |
| MONOCYTES | 3.5 | % | 2-10 |
| EOSINOPHILS | 2.6 | % | 1-6 |
| BASOPHILS | 0.3 | % | 0-2 |
| IMMATURE GRANULOCYTE PERCENTAGE(IG%) | 0.3 | % | 0-0.5 |
| NEUTROPHILS - ABSOLUTE COUNT | 3.99 | X 10³ / µL | 2.0-7.0 |
| LYMPHOCYTES - ABSOLUTE COUNT | 2.06 | X 10³ / µL | 1.0-3.0 |
| MONOCYTES - ABSOLUTE COUNT | 0.23 | X 10³ / µL | 0.2 - 1.0 |
| BASOPHILS - ABSOLUTE COUNT | 0.02 | X 10³ / µL | 0.02 - 0.1 |
| EOSINOPHILS - ABSOLUTE COUNT | 0.17 | X 10³ / µL | 0.02 - 0.5 |
| IMMATURE GRANULOCYTES(IG) | 0.02 | X 10³ / µL | 0-0.3 |
| TOTAL RBC | 4.89 | X 10^6/µL | 4.5-5.5 |
| NUCLEATED RED BLOOD CELLS | 0.01 | X 10³ / µL | <0.01 |
| NUCLEATED RED BLOOD CELLS % | 0.01 | % | <0.01 |
| HEMOGLOBIN | 14.2 | g/dL | 13.0-17.0 |
| HEMATOCRIT(PCV) | 42.7 | % | 40.0-50.0 |
| MEAN CORPUSCULAR VOLUME(MCV) | 87.3 | fL | 83.0-101.0 |
| MEAN CORPUSCULAR HEMOGLOBIN(MCH) | 29 | pq | 27.0-32.0 |
| MEAN CORP.HEMO.CONC(MCHC) | 33.3 | g/dL | 31.5-34.5 |
| RED CELL DISTRIBUTION WIDTH - SD(RDW-SD) | 40.1 | fL | 39-46 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV) | 12.6 | % | 11.6-14 |
| **PLATELET DISTRIBUTION WIDTH(PDW)** | **8.6** | **fL** | **9.6-15.2** |
| MEAN PLATELET VOLUME(MPV) | 8.5 | fL | 6.5-12 |
| PLATELET COUNT | 268 | X 10³ / µL | 150-410 |
| **PLATELET TO LARGE CELL RATIO(PLCR)** | **13** | **%** | **19.7-42.4** |
| PLATELETCRIT(PCT) | 0.23 | % | 0.19-0.39 |

**Remarks :** Alert!!! Predominantly normocytic normochromic with ovalocytes. Platelets:Appear adequate in smear.

**Please Correlate with clinical conditions.**
**Method : Fully automated bidirectional analyser (6 Part Differential SYSMEX XN-1000)**
**(This device performs hematology analyses according to the Hydrodynamic Focussing (DC method), Flow Cytometry Method (using a semiconductor laser), and SLS- hemoglobin method)**

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REPORT

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**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| ALPHA-1-ANTITRYPSIN (AAT) | IMMUNOTURBIDIMETRY | 96.35 | mg/dL |

**Reference Range :-**

90 - 200 mg/dL

Clinical Significance ;
Alpha-1-antitrypsin (AAT) is a serine protease inhibitor and the third most abundant protein in circulation. AAT levels can increase 3 to 5 folds in states of systemic inflammation or infection. Increased levels are also seen in Covid-19 patients. Usually, the increase in AAT is directly proportional to the increase in IL6, supporting an anti inflammatory function. It is also considered that patients with Alpha-1-antitrypsin deficiency (AATD) might be at increased risk of SARS-CoV-2 infection and development of severe COVID-19.

Alpha-1 antitrypsin (AAT) deficiency can cause various medical complications of the lungs, liver, and skin, including COPD, emphysema, chronic bronchitis, cirrhosis of the liver and other side effects of the excess enzyme.

Specifications;
Precision (%CV) : Intra-assay %CV: 1.4 %, Inter-assay %CV: 1.36%

Kit Validation reference ;
1.Janciauskiene SM, Bals R, Koczulla R, et al. The discovery of Alpha1-antitrypsin and its role in health and disease. Respir Med, 2011, 105(8) : 1129-1139
2.Sun Z, Yang P. Role of imbalance between neutrophil elastase and alpha1-antitrypsin in cancer development and progression. Lancet Oncol, 2004, 5(3) : 182-190

**Please correlate with clinical conditions.**
**Method:-** Polyethylene glycol(PEG)-enhanced immunoturbidimetric

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
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**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| HOMOCYSTEINE | PHOTOMETRY | 12.94 | µmol/L |

**Reference Range :-**

Normal: < 30 µmol/L

Clinical Significance:
Homocysteine is linked to increased risk of premature coronary artery disease, stroke and thromboembolism. Moreover, alzheimers disease, osteoporosis, venous thrombosis, schizophrenia, cognitive deficiency and pregnancy complications also elevates Homocysteine levels.

High Values:
Elevated homocysteine levels might be due to increasing age, genetic traits, drugs, renal dysfunction and dietary deficiency of vitamins or smoking. To lower your homocysteine, eat more green vegetables, stop smoking, alcohol. Folic acid helps lowering elevated levels.

Specifications:
Precision %CV :- Intra assay %CV- 4.5 % , Inter assay %CV-5.87 % Sensitivity : 0.4 umol/L

Kit Validation Reference:
Eikelboom JW, et al Ann Intern Med 131 : 363-75 (1999)

**Please correlate with clinical conditions.**
**Method:-** ENZYMATIC ASSAY

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
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**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign

REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| **ANTI CCP (ACCP)** | E.L.I.S.A | 7.55 | AU/mL |

**Reference Range :**
Negative : < 10
Positive : >=10

Clinical Significance :

Anti-Cyclic-Citrullinated-Peptide (Anti-CCP) Antibodies hold promise for early and more accurate detection of Rheumatoid Arthritis before the disease proceeds into an irreversible damage.

Specifications: Specificity : 94 % , Sensitivity : 76 %

Kit Validation reference:
Vossenaar ER et al.,Arthritis Rheum.,50, 3485, 2004
**Method :** INDIRECT SOLID PHASE ENZYME IMMUNOASSAY

| | | | |
|---|---|---|---|
| **ANTI NUCLEAR ANTIBODIES (ANA)** | E.L.I.S.A | 14.44 | AU/mL |

**Reference Range :**

NEGATIVE : <25 POSITIVE : >= 25

Clinical Significance:
Autoimmune diseases are characterized by abnormal functioning of Immune System where cell recognition mechanism fails to distinguish " Self " and " non-self " antigens. Presence of ANA autoantibodies associated with rhematic autoimmune diseases such as systemic Lupus Erythematosus (SLE), Sjogren Syndrome, Scleroderma and mixed connective tissue disease (MCTD).

Specifications:
Specification:- Precision: Intra assay (%CV): <=6.6, Inter assay (%CV): <=13.3, Sensitivity: 87.1%, Specificity: 80%.

Kit Validation Reference:
Antinuclear Antibody The Lancet, September 15, 1984: 611-13
**Method :** INDIRECT SOLID PHASE IMMUNOASSAY

**Please correlate with clinical conditions.**

Dummy Report

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**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| CYSTATIN C | IMMUNOTURBIDIMETRY | 0.92 | mg/L |

**Reference Range :-**

<= 60 years: <= 1.03 mg/L
> 60 years : < 1.50 mg/L

Clinical significance

Cystatin c, is a small 13-kda protein and is a member of the cysteine proteinase inhibitor family, it is produced at a constant rate by all nucleated cells. Due to its small size it is freely filtered by the glomerulus and is not secreted but is fully reabsorbed and broken down by the renal tubules. This means that the primary determinate of blood Cystatin c levels is the rate at which it is filtered at the glomerulus making it an excellent gfr marker. Cystatin c is also a marker of inflammation and like many other markers of inflammation; its serum concentration may be higher in patients with decreased renal clearance. There is mounting evidence, however, that Cystatin c may be a predictor of adverse outcomes independent of renal function with its higher sensitivity to detect a reduced GFR than Creatinine determination, also in the so-called "Creatinine-blind" range. Thus, Cystatin c is suggested to be a better marker for GFR than the ubiquitous serum Creatinine.

Reference

1. Barrett aj, Davies me, Grubb a. the place of human gamma-trace (Cystatin c) among the cysteine proteinase inhibitors. Biochem biophys res common 1984; 120: 631-6.

2. Grubb a. diagnostic value of analysis of Cystatin c and protein HC in biological fluids. Clin Nephrol 1992; 38: S20-7.

**Please correlate with clinical conditions.**
**Method:-** LATEX ENHANCED IMMUNOTURBIDIMETRY

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
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**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| **25-OH VITAMIN D (TOTAL)** | C.L.I.A | 59.57 | ng/mL |

**Reference Range :**
DEFICIENCY : <20 ng/ml || INSUFFICIENCY : 20-<30 ng/ml
SUFFICIENCY : 30-100 ng/ml || TOXICITY : >100 ng/ml

Clinical Significance:

Vitamin D is a fat soluble vitamin that has been known to help the body absorb and retain calcium and phosphorous; both are critical for building bone health. Decrease in vitamin D total levels indicate inadequate exposure of sunlight, dietary deficiency, nephrotic syndrome. Increase in vitamin D total levels indicate Vitamin D intoxication.

Specifications: Precision: Intra assay (%CV):5.3%, Inter assay (%CV):11.9% ; Sensitivity:3.2 ng/ml.

Kit Validation Reference: Holick MF. Vitamin D Deficiency. N Engl J Med. 2007;357:266–81.
**Method :** FULLY AUTOMATED CHEMI LUMINESCENT IMMUNO ASSAY

| | | | |
|---|---|---|---|
| **VITAMIN B-12** | **C.L.I.A** | **164** | **pg/mL** |

**Reference Range :**

Normal : 211 - 911 pg/ml

Clinical significance :
Vitamin B12 or cyanocobalamin, is a complex corrinoid compound found exclusively from animal dietary sources, such as meat, eggs and milk. It is critical in normal DNA synthesis, which in turn affects erythrocyte maturation and in the formation of myelin sheath. Vitamin-B12 is used to find out neurological abnormalities and impaired DNA synthesis associated with macrocytic anemias. For diagnostic purpose, results should always be assessed in conjunction with the patients medical history, clinical examination and other findings.

Specifications: Intra assay (%CV):5.0%, Inter assay (%CV):9.2 %;Sensitivity:45 pg/ml

Kit Validation reference:
Chen IW, Sperling MI, Heminger LA. Vitamin B12. In: Pesce AJ, Kaplan LA, eds. Methods in Clinical Chemistry. St. Louis: CV Mosby; 1987:569–73.
**Method :** COMPETITIVE CHEMI LUMINESCENT IMMUNO ASSAY

**Please correlate with clinical conditions.**

Dummy Report

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**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| **APOLIPOPROTEIN - A1 (APO-A1)** | IMMUNOTURBIDIMETRY | 109 | mg/dL |

**Reference Range :**
Male : 86 - 152
Female : 94 - 162
**Method :** FULLY AUTOMATED RATE IMMUNOTURBIDIMETRY – BECKMAN COULTER

| | | | |
|---|---|---|---|
| **APOLIPOPROTEIN - B (APO-B)** | IMMUNOTURBIDIMETRY | 80 | mg/dL |

**Reference Range :**
Male : 56 - 145
Female : 53 - 138
**Method :** FULLY AUTOMATED RATE IMMUNOTURBIDIMETRY – BECKMAN COULTER

| | | | |
|---|---|---|---|
| **APO B / APO A1 RATIO (APO B/A1)** | CALCULATED | 0.7 | Ratio |

**Reference Range :**
Male : 0.40 - 1.26
Female : 0.38 - 1.14
**Method :** DERIVED FROM SERUM APO A1 AND APO B VALUES

**Please correlate with clinical conditions.**

Dummy Report

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REPORT

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**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
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**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP) | IMMUNOTURBIDIMETRY | 1.2 | mg/L |

**Reference Range :-**

< 1.00 - Low Risk
1.00 - 3.00 - Average Risk
>3.00 - 10.00 - High Risk
> 10.00 - Possibly due to Non-Cardiac Inflammation

Disclaimer: Persistent unexplained elevation of HSCRP >10 should be evaluated for non-cardiovascular etiologies such as infection , active arthritis or concurrent illness.

Clinical significance:
High sensitivity C- reactive Protein ( HSCRP) can be used as an independent risk marker for the identification of Individuals at risk for future cardiovascular Disease. A coronary artery disease risk assessment should be based on the average of two hs-CRP tests, ideally taken two weeks apart.

Kit Validation Reference:
1.Clinical management of laboratory date in medical practice 2003-3004, 207(2003).
2.Tietz : Textbook of Clinical Chemistry and Molecular diagnostics :Second edition :Chapter 47:Page no.1507- 1508.

**Please correlate with clinical conditions.**
**Method:-** FULLY AUTOMATED LATEX AGGLUTINATION – BECKMAN COULTER

Dummy Report

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**Labcode** :
**Barcode** :

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**HOME COLLECTION :**
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**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| **IRON** | PHOTOMETRY | 134 | µg/dL |
| **Reference Range :** Male : 65 - 175 Female : 50 - 170 **Method :** FERROZINE METHOD WITHOUT DEPROTEINIZATION | | | |
| **TOTAL IRON BINDING CAPACITY (TIBC)** | PHOTOMETRY | 232 | µg/dL |
| **Reference Range :** Male: 225 - 535 µg/dl Female: 215 - 535 µg/dl **Method :** SPECTROPHOTOMETRIC ASSAY | | | |
| **% TRANSFERRIN SATURATION** | **CALCULATED** | **57.76** | **%** |
| **Reference Range :** 13 - 45 **Method :** DERIVED FROM IRON AND TIBC VALUES | | | |
| **FERRITIN** | C.L.I.A | 91 | ng/mL |
| **Reference Range :** Men: 22-322 ng/ml Women: 10-291 ng/ml **Method :** FULLY AUTOMATED BIDIRECTIONALLY INTERFACED CHEMI LUMINESCENT IMMUNO ASSAY | | | |
| **UNSAT.IRON-BINDING CAPACITY(UIBC)** | **PHOTOMETRY** | **98** | **µg/dL** |
| **Reference Range :** 162 - 368 **Method :** SPECTROPHOTOMETRIC ASSAY | | | |
| **FOLATE** | C.L.I.A | 8.1 | ng/mL |
| **Reference Range :** > 5.38 ng/ml | | | |

Clinical Significance: Low folate intake, malabsorption as a result of gastrointestinal diseases, pregnancy, and drugs such as phenytoin are causes of folate deficiency.3 Folate deficiency is also associated with chronic alcoholism. Serum folate measurement provides an early index of folate status.

Specifications: Precision: Intra assay (%CV): 7.93, Inter assay (%CV): 7.19, Sensitivity: 0.35 ng/mL.

Kit Validation References: Steinkamp RC. Vitamin B12 and folic acid: clinical and pathophysiological considerations. In: Brewster MA, Naito HK, eds. Nutritional Elements and Clinical Biochemistry. New York: Plenum Publishing Corp.; 1980:169–240
**Method :** COMPETITIVE CHEMI LUMINESCENT IMMUNO ASSAY

**Please correlate with clinical conditions.**

Dummy Report

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**Sample Type** : SERUM
**Labcode** :
**Barcode** :

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REPORT

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**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| INSULIN - FASTING | C.L.I.A | 4.8 | µU/mL |

**Reference Range :-**

1.9-23 µU/mL

Clinical Significance

Type I (Insulin dependent: "Juvenile") diabetes is due to a destruction of the beta cells, with a consequence of absolute lack of insulin. In type II (Non insulin-dependent: "Maturity onset") diabetes, insulin resistance may play an important role; However after several years of evolution, beta-cells failure may occur, leading to a relative insulinopenia requiring, in some cases, insulin administration. Insulin resistance is associated with high circulation levels of the hormone.

For diagnostic purpose, results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

Specifications:

Precision: Intra Assay (%CV): 4.20 %, Inter Assay (%CV): 5.60%; Sensitivity: 0.03 µU/mL

External quality control program participation:

College Of American Pathologists: Insulin Survey (Ing): Cap Number: 7193855-01

Kit validation references:

Howanitz PJ, Howanitz JH, Henry JB. Carbohydrates.Clinical Diagnosis and Management by Laboratory Methods 1991 ;172-182.edited by Henry JB, Philadelphia, W.B Saunders Company.

**Please correlate with clinical conditions.**
**Method:-** One step Immunoenzymatic ( Sandwich) assay.

Dummy Report

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**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

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REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| **FRUCTOSAMINE** | PHOTOMETRY | 234.4 | µmol/L |

**Reference Range :**

Normal < 286 µmol/L

Clinical Significance:

Fructosamine assay is useful in monitoring the degree of glycemia over short-to-intermediate time frames (1-3 weeks) concentration greater than the established normal range is an indication of prolonged hyperglycemia of 1-3 weeks or longer. The higher fructosamine value, poorer is the degree of glycemia control.

Specifications:

Precision %CV : Intra assay %CV- 3.2% , Inter assay %CV-4.0%, Sensitivity:- 290 umol/L

Kit Validation Reference:

Howey JEA, Browning MCK, Fraser CG. Assay of serum fructosamine that minimizes standardization and matrix problems: Use to assess components of biological va-riation. Clin Chem 1987; 33: 269- 272.

**Method :** NITROBLUE TETRAZOLIUM ASSAY (NBT)

| | | | |
|---|---|---|---|
| **BLOOD KETONE (D3HB)** | PHOTOMETRY | 0.52 | mg/dL |

**Reference Range :**
0.21-2.81 mg/dL

Clinical Significance:
Three types of ketones can be produced in body D-3- Hydroxybutyrate, Acetoacetate and Acetone. D-3- Hydroxybutyrate accounts for approximately 75% of the ketone bodies. During periods of ketosis, D-3- Hydroxybutyrate increases more than the other two. It has been shown to be a better index of ketoacidosis. In diabetics, D-3- Hydroxybutyrate is needed for the assessment of the severity of diabetic coma and to calculate insulin requirements.

Speficcation:
Precision: Intra assay (%CV): 4.53, Inter assay (%CV): 2.9, Sensitivity: 10.41 mg/dL.

Kit validation references:
Mcmurray, C.H., Blanchflower, W.J., Rice, D.A., ClinChem., 1984;30:No.3.

**Method :** ENZYMATIC (KINETIC)

**Please correlate with clinical conditions.**

**Sample Collected on (SCT)** : Sample collection time
**Sample Received on (SRT)** : Sample receiving time at Lab
**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign



Dummy Report

**PROCESSED AT :**

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REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| Lipoprotein (a) [Lp(a)] | IMMUNOTURBIDIMETRY | 5.6 | mg/dL |

**Reference Range :-**

Adults : < 30.0 mg/dl

Clinical Significance:
Determination of LPA may be useful to guide management of individuals with a family history of CHD or with existing disease. The levels of LPA in the blood depends on genetic factors; The range of variation in a population is relatively large and hence for diagnostic purpose, results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

Specifications:
Precision %CV :- Intra assay %CV- 4.55% , Inter assay %CV-0.86 %

Kit Validation Reference:
Tietz NW,Clinical Guide to Laboratory Tests Philadelphia WB. Saunders 1995 : 442-444

**Please correlate with clinical conditions.**
**Method:-** LATEX ENHANCED IMMUNOTURBIDIMETRY

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
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**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

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REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| LP-PLA2 | PHOTOMETRY | 166 | nmol/min/mL |

**Reference Range :-**

Low Risk : < 225 nmol/min/mL
High Risk : >= 225 nmol/min/mL

Clinical Significance:

Lp-PLA2, is an enzyme produced by inflammatory cells. It is predominantly associated with low-density lipoprotein (LDL) and high-density lipoprotein (HDL). Lp-PLA2 is a specific marker of vascular inflammation and found to be upregulated in atherosclerotic lesions especially in complex plaque prone to rupture. A meta-analysis found that Lp-PLA2 levels are positively correlated with increased risk of developing coronary heart disease and stroke. Lp-PLA2 is not an acute phase reactant and thus is unaffected by systemic inflammatory processes. Lp-PLA2 activity should be interpreted in conjunction with clinical evaluation and other risk factor assessment.

Specification:

Precision %CV : Intra assay %CV- 1.50% , Inter assay %CV-3.80%

Kit Validation Reference:

Alexander Thompson etal., The Lp-PLA2 Studies Collaboration (2010). "Lipoprotein-associated phospholipase A2 and risk of coronary disease, stroke, and mortality: collaborative analysis of 32 prospective studies". The Lancet 375 (9725): 1536-1544

**Please correlate with clinical conditions.**

**Method:-** ENZYMATIC ASSAY

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
**Sample Received on (SRT)** : Sample receiving time at Lab
**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign

REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| SERUM COPPER | PHOTOMETRY | 82.4 | µg/dL |

**Reference Range :-**

Male : 63.5 - 150
Female : 80 - 155

Clinical significance:
Copper is an important trace element and a component of numerous enzymes and proteins involved in energy production, connective tissue formation, melanin synthesis, iron metabolism, development of central nervous system, angiogenesis as well as an antioxidant. Deficiency can cause- Malnourishment, cardiovascular disease, anemia & neuropathy, toxicity may be manifested as acute renal failure, gastroenteritis & chronic liver disease.

Specifications:
Precision: Intra assay (%CV): 1.17, Inter assay (%CV): 2.32.

Kit validation references:
Thomas L. Clinical Laboratory Diagnostics. 1st ed. Frankfurt: TH-Books Verlagsgesellschaft; 1998. p. 337-8

**Please correlate with clinical conditions.**
**Method:-** 3,5-DIBR-PAESA

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
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**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

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**REF. BY** : XXXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| SERUM ZINC | PHOTOMETRY | 114.8 | µg/dL |

**Reference Range :-**

52 - 286

Clinical Significance:
Zinc is one of the essential trace elements in the body. Its metalloenzymes play a key rple in protein and nucleic acid synthesis, gene expression, wound healing, as an antioxidant, etc. Deficiency can cause- Poor wound healing, gastroenteritis, impaired spermatogenesis, Alzheimer's disease, etc. Toxicity may be manifested as pancreatitis, gastric ulcer, anemia, pulmonary fibrosis.

Specifications:
Precision: Intra assay (%CV): 2.02, Inter assay (%CV): 2.22.

Kit Validation References:
Thomas L. Clinical Laboratory Diagnostics. 1st ed. Frankfurt: TH-Books Verlagsgesellschaft; 1998. p. 347-9

**Please correlate with clinical conditions.**

**Method:-** NITRO - PAPS

Dummy Report

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**Barcode** :

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REPORT

**NAME** : XXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| TESTOSTERONE | C.L.I.A | 244.46 | ng/dL |

**Reference Range :-**

Adult Male
21 - 49 Yrs : 164.94 - 753.38 || 50 - 89 Yrs : 86.49 - 788.22
Adult Female
Pre-Menopause : 12.09 - 59.46 || Post-Menopause: < 7.00 - 48.93
Boys
2-10 Years : < 7.00 - 25.91
11 Years : < 7.00 - 341.53
12 Years : < 7.00 - 562.59
13 Years : 9.34 - 562.93
14 Years : 23.28 - 742.46
15 Years : 144.15 - 841.44
16-21 Years : 118.22 - 948.56
Girls
2-10 Years : < 7.00 - 108.30
11-15 Years : < 7.00 - 48.40
16-21 Years : 17.55 - 50.41

Clinical Significance: Clinical evaluation of serum testosterone, along with serum LH, assists in evaluation of Hypogonadal males. Major causes of lowered testosterone in males include Hypogonadotropic hypogonadism, testicular failure Hyperprolactinema, Hypopituitarism some types of liver and kidney diseases and critical illness.

Specifications: Precision: Intra assay (%CV): 8.5 %, Inter assay (%CV): 12.6%; Sensitivity: 7 ng/dL.

Kit Validation Reference: Kicklighter EJ, Norman RJ. The gonads. In: Kaplan LA, Pesce AJ, eds. Clinical Chemistry: Theory, Analysis, Correlation. 2nd ed. St. Louis: CV Mosby; 1989:657–662.

**Please correlate with clinical conditions.**

**Method:-** COMPETITIVE CHEMI LUMINESCENT IMMUNO ASSAY

Dummy Report

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**Labcode** :
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REPORT

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**REF. BY** : XXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| AMYLASE | PHOTOMETRY | 40.1 | U/L |

**Reference Range :-**

Adults : 28-100 U/L

Interpretation:
Lipemic Sera (Hypertriglyceridemia) may contain inhibitors, Which falsely depress results. About 20% of patients with Acute Pancreatitis have abnormal lipids. Normal serum amylase may occur in Pancreatitis, Especially relapsing and chronic pancreatitis. Moderate increases may be reported in normal pregnancy.

Clinical Significance:
Causes of high Serum Amylase include Acute Pancreatitis, Pancreatic Pseudocyst, Pancreatic Ascites, Pancreatic Abscess, Neoplasm in or adjacent to Pancreas, Trauma to Pancreas, and common Duct Stones. Nonpancreatic Causes include inflammatory salivary lesions (Eg, Mumps), Perforated Peptic Ulcer, Intestinal Obstruction, Biliary Tract Disease, Peritonitis, Acute Appendicitis, Diabetic Ketoacidosis, and Extrapancreatic Carcinomas. Amylase levels more than 25-fold the upper limit of normal are often found when metastatic tumors produce Ectopic Amylase.

Specifications:
Precision: Intra assay (%CV): 2.82, Inter assay (%CV): 2.49, Sensitivity: 10.9 U/L.

Kit Validation References:
Rauscher, E., et coll., Fresenius Z. Analyt. Chem. 324 (1986) 304-305.

**Please correlate with clinical conditions.**
**Method:-** ENZYMATIC COLORIMETRIC TEST

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
**Sample Received on (SRT)** : Sample receiving time at Lab
**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

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REPORT

**NAME** : XXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| LIPASE | PHOTOMETRY | 44.5 | U/L |

**Reference Range :-**

Adults : 5.6 - 51.3 U/L

Interpretation:

For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings like serum amylase. Serum Lipase is usually normal in patients with elevated serum amylase, having peptic ulcer, salivary adenitis, inflammatory bowel disease, intestinal obstruction, and macroamylasemia. Lipemic sera may interfere with results.

Clinical Significance:
High serum Lipase is a specific marker for pancreatitis; after acute pancreatitis the Lipase activity increases within 4-8 hours, reaches a peak after 24 hours and decreases after 8 to 14 days. However, there is no correlation between the Lipase activity determined in serum and the extent of damage to the pancreas.

Specifications:
Precision: Intra assay (%CV): 3.35, Inter assay (%CV): 2.46, Sensitivity: 3.5 U/L.

Kit Validation References:
Tietz Nw Et Al. Lipase In Serum - The Elusive Enzyme: An Overview. Clin Chem 1993; 39:746-756.

**Please correlate with clinical conditions.**
**Method:-** ENZYMATIC COLORIMETRIC ASSAY

Dummy Report

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**Barcode** :

Doctor 1 Sign Doctor 2 Sign

REPORT

**NAME** : XXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**PATIENTID** :

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

| TEST NAME | TECHNOLOGY | VALUE | UNITS | NORMAL RANGE |
|---|---|---|---|---|
| TOTAL CHOLESTEROL | PHOTOMETRY | 142 | mg/dL | < 200 |
| **HDL CHOLESTEROL - DIRECT** | **PHOTOMETRY** | **37** | **mg/dL** | **40-60** |
| **HDL / LDL RATIO** | **CALCULATED** | **0.38** | **Ratio** | **> 0.40** |
| LDL CHOLESTEROL - DIRECT | PHOTOMETRY | 98 | mg/dL | < 100 |
| TRIG / HDL RATIO | CALCULATED | 2.24 | Ratio | < 3.12 |
| TRIGLYCERIDES | PHOTOMETRY | 83 | mg/dL | < 150 |
| TC/ HDL CHOLESTEROL RATIO | CALCULATED | 3.9 | Ratio | 3 - 5 |
| LDL / HDL RATIO | CALCULATED | 2.6 | Ratio | 1.5-3.5 |
| VLDL CHOLESTEROL | CALCULATED | 16.6 | mg/dL | 5 - 40 |
| NON-HDL CHOLESTEROL | CALCULATED | 105.4 | mg/dL | < 160 |

**Please correlate with clinical conditions.**

**Method :**

CHOL - Cholesterol Oxidase, Esterase, Peroxidase
HCHO - Direct Enzymatic Colorimetric
HD/LD - Derived from HDL and LDL values.
LDL - Direct Measure
TRI/H - Derived from TRIG and HDL Values
TRIG - Enzymatic, End Point
TC/H - DERIVED FROM SERUM CHOLESTEROL AND HDL VALUES
LDL/ - Derived from serum HDL and LDL Values
VLDL - DERIVED FROM SERUM TRIGLYCERIDE VALUES
NHDL - Derived from serum Cholesterol and HDL values

***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 | | |

**Alert !!! 10-12 hours fasting is mandatory for lipid parameters. If not, values might fluctuate.**

**Sample Collected on (SCT)** : Sample collection time
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**Sample Type** : SERUM
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Doctor 1 Sign Doctor 2 Sign



Dummy Report

REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**PATIENTID** :

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

| TEST NAME | TECHNOLOGY | VALUE | UNITS | NORMAL RANGE |
|---|---|---|---|---|
| ALKALINE PHOSPHATASE | PHOTOMETRY | 73.5 | U/L | 45-129 |
| BILIRUBIN - TOTAL | PHOTOMETRY | 0.68 | mg/dL | 0.3-1.2 |
| BILIRUBIN -DIRECT | PHOTOMETRY | 0.13 | mg/dL | < 0.3 |
| BILIRUBIN (INDIRECT) | CALCULATED | 0.55 | mg/dL | 0-0.9 |
| SGOT / SGPT RATIO | CALCULATED | 1.43 | Ratio | < 2 |
| ASPARTATE AMINOTRANSFERASE (SGOT ) | PHOTOMETRY | 15.2 | U/L | < 35 |
| ALANINE TRANSAMINASE (SGPT) | PHOTOMETRY | 10.6 | U/L | < 45 |
| GAMMA GLUTAMYL TRANSFERASE (GGT) | PHOTOMETRY | 20.4 | U/L | < 55 |
| PROTEIN - TOTAL | PHOTOMETRY | 6.49 | gm/dL | 5.7-8.2 |
| ALBUMIN - SERUM | PHOTOMETRY | 4.09 | gm/dL | 3.2-4.8 |
| **SERUM GLOBULIN** | **CALCULATED** | **2.4** | **gm/dL** | **2.5-3.4** |
| SERUM ALB/GLOBULIN RATIO | CALCULATED | 1.7 | Ratio | 0.9 - 2 |

**Please correlate with clinical conditions.**

**Method :**

ALKP - Modified IFCC method
BILT - Vanadate Oxidation
BILD - Vanadate Oxidation
BILI - DERIVED FROM SERUM TOTAL AND DIRECT BILIRUBIN VALUES
OT/PT - Derived from SGOT and SGPT values.
SGOT - IFCC* WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION
SGPT - IFCC* WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION
GGT - Modified IFCC method
PROT - BIURET METHOD
SALB - ALBUMIN BCG¹METHOD (COLORIMETRIC ASSAY ENDPOINT)
SEGB - DERIVED FROM SERUM ALBUMIN AND PROTEIN VALUES
A/GR - DERIVED FROM SERUM ALBUMIN AND PROTEIN VALUES

Dummy Report

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Doctor 1 Sign Doctor 2 Sign

REPORT

**NAME** : XXXXXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**PATIENTID** :

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

| TEST NAME | TECHNOLOGY | VALUE | UNITS | NORMAL RANGE |
|---|---|---|---|---|
| CALCIUM | PHOTOMETRY | 9.62 | mg/dL | 8.8-10.6 |
| URIC ACID | PHOTOMETRY | 5.74 | mg/dL | 4.2 - 7.3 |
| UREA (CALCULATED) | CALCULATED | 27.61 | mg/dL | Adult : 17-43 |
| BLOOD UREA NITROGEN (BUN) | PHOTOMETRY | 12.9 | mg/dL | 7.94 - 20.07 |
| UREA / SR.CREATININE RATIO | CALCULATED | 29.06 | Ratio | < 52 |
| CREATININE - SERUM | PHOTOMETRY | 0.95 | mg/dL | 0.72-1.18 |
| BUN / SR.CREATININE RATIO | CALCULATED | 13.58 | Ratio | 9:1-23:1 |
| SODIUM | I.S.E | 141 | mmol/L | 136 - 145 |
| CHLORIDE | I.S.E | 107 | mmol/L | 98 - 107 |

**Please correlate with clinical conditions.**

**Method :**

CALC - ARSENAZO III METHOD, END POINT.
URIC - Uricase / Peroxidase Method
UREAC - Derived from BUN Value.
BUN - KINETIC UV ASSAY.
UR/CR - Derived from UREA and Sr.Creatinine values.
SCRE - CREATININE ENZYMATIC METHOD
B/CR - DERIVED FROM SERUM BUN AND CREATININE VALUES
SOD - ION SELECTIVE ELECTRODE
CHL - ION SELECTIVE ELECTRODE

Dummy Report

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**PROCESSED AT :**

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REPORT

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**REF. BY** : XXXXXXXXXXXXXXXXXXX

**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS | REFERENCE RANGE |
|---|---|---|---|---|
| TOTAL TRIIODOTHYRONINE (T3) | C.L.I.A | 85 | ng/dL | 60-200 |
| **TOTAL THYROXINE (T4)** | **C.L.I.A** | **4.3** | **µg/dL** | **4.5-12** |
| TSH - ULTRASENSITIVE | C.L.I.A | 2.235 | µIU/mL | 0.55-4.78 |

**Comments :** ***

**The Biological Reference Ranges is specific to the age group. Kindly correlate clinically.**

**Method :**

T3 - COMPETITIVE CHEMI LUMINESCENT IMMUNO ASSAY
T4 - COMPETITIVE CHEMI LUMINESCENT IMMUNO ASSAY
USTSH - Third Generation Ultrasensitive Chemi Luminescent Immuno Assay

**Disclaimer :**

Results should always be interpreted using the reference range provided by the laboratory that performed the test. Different laboratories do tests using different technologies, methods and using different reagents which may cause difference
In reference ranges and hence it is recommended to interpret result with assay specific reference ranges provided in the reports.

Dummy Report

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Doctor 1 Sign Doctor 2 Sign

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REPORT

**NAME** : XXXXXXXXXXXXXXXXX
**REF. BY** : XXXXXXXXXXXXXXXXX
**TEST ASKED** : AAROGYAM 1.7

**HOME COLLECTION :**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PATIENTID** :

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| EST. GLOMERULAR FILTRATION RATE (eGFR) | CALCULATED | 94 | mL/min/1.73 m2 |

**Reference Range :-**

> = 90 : Normal
60 - 89 : Mild Decrease
45 - 59 : Mild to Moderate Decrease
30 - 44 : Moderate to Severe Decrease
15 - 29 : Severe Decrease

Clinical Significance

The normal serum creatinine reference interval does not necessarily reflect a normal GFR for a patient. Because mild and moderate kidney injury is poorly inferred from serum creatinine alone. Thus, it is recommended for clinical laboratories to routinely estimate glomerular filtration rate (eGFR), a "gold standard" measurement for assessment of renal function, and report the value when serum creatinine is measured for patients 18 and older, when appropriate and feasible. It cannot be measured easily in clinical practice, instead, GFR is estimated from equations using serum creatinine, age, race and sex. This provides easy to interpret information for the doctor and patient on the degree of renal impairment since it approximately equates to the percentage of kidney function remaining. Application of CKD-EPI equation together with the other diagnostic tools in renal medicine will further improve the detection and management of patients with CKD.

Reference

Levey AS, Stevens LA, Schmid CH, Zhang YL, Castro AF, 3rd, Feldman HI, et al. A new equation to estimate glomerular filtration rate. Ann Intern Med. 2009;150(9):604-12.

**Please correlate with clinical conditions.**
**Method:-** CKD-EPI Creatinine Equation

**~~ End of report ~~**

Dummy Report

**Sample Collected on (SCT)** : Sample collection time
**Sample Received on (SRT)** : Sample receiving time at Lab
**Report Released on (RRT)** : Report release time
**Sample Type** : SERUM
**Labcode** :
**Barcode** :

Doctor 1 Sign Doctor 2 Sign

## CONDITIONS OF REPORTING

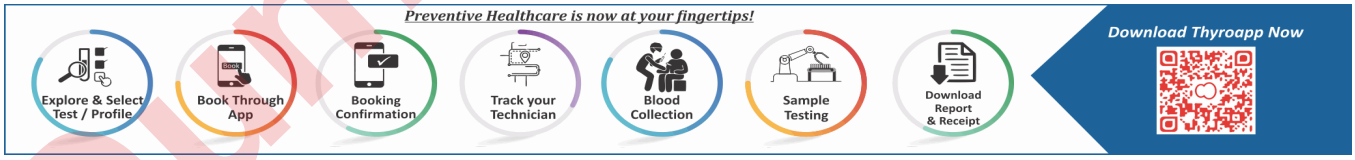
- The reported results are for information and interpretation of the referring doctor only.
- It is presumed that the tests performed on the specimen belong to the patient; named or identified.
- Results of tests may vary from laboratory to laboratory and also in some parameters from time to time for the same patient.
- Should the results indicate an unexpected abnormality, the same should be reconfirmed.
- Only such medical professionals who understand reporting units, reference ranges and limitations of technologies should interpret results.
- This report is not valid for medico-legal purpose.
- Neither Thyrocare, nor its employees/representatives assume any liability, responsibility for any loss or damage that may be incurred by any person as a result of presuming the meaning or contents of the report.
- Thyrocare Discovery video link :- https://youtu.be/nbdYeRgYyQc
- For clinical support please contact @8450950852,8450950853,8450950854 between 10:00 to 18:00

## EXPLANATIONS

- Majority of the specimen processed in the laboratory are collected by Pathologists and Hospitals we call them as "Clients".
- **Name** - The name is as declared by the client and recored by the personnel who collected the specimen.
- **Ref.Dr** - The name of the doctor who has recommended testing as declared by the client.
- **Labcode** - This is the accession number in our laboratory and it helps us in archiving and retrieving the data.
- **Barcode** - This is the specimen identity number and it states that the results are for the specimen bearing the barcode (irrespective of the name).
- **SCP** - Specimen Collection Point - This is the location where the blood or specimen was collected as declared by the client.
- **SCT** - Specimen Collection Time - The time when specimen was collected as declared by the client.
- **SRT** - Specimen Receiving Time - This time when the specimen reached our laboratory.
- **RRT** - Report Releasing Time - The time when our pathologist has released the values for Reporting.
- **Reference Range** - Means the range of values in which 95% of the normal population would fall.

## SUGGESTIONS

- Values out of reference range requires reconfirmation before starting any medical treatment.
- Retesting is needed if you suspect any quality shortcomings.
- Testing or retesting should be done in accredited laboratories.
- For suggestions, complaints or feedback, write to us at **info@thyrocare.com** or call us on **022-3090 0000 / 6712 3400**
- SMS:<Labcode No.> to **9870666333**






Dummy Report