Thyrocare

Tests you can trust

Name : XXXXXXXX

Date : XXXXXXXXX

Test Asked : Jaanch Anemia Profile Advanced

Report Status : Complete Report

Dummy Report



First National Diagnostic Chain to have 100% of its Labs with NABL Accreditation#

98% Reports released within 06 Hours of sample reaching the lab+

9 out of 10 Doctors Trust that Thyrocare reports are Accurate & Reliable*

1200+ Tests & Profiles

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Unique Barcode Tracking

Fully Automated Machines Inspected Daily

Abnormal Values Re-Checked Twice

Reports Verified By Expert MD Pathologists Stationed at Every Lab

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Scan the QR code inside the report to check authenticity of reported values

QR code will remain active for 30 days from report release date

Accredited by

NABL From 2005#

ISO 9001: 2015 - From 2015

CAP From 2007~

Processed At :

Thyrocare
Tests you can trust

Thyrocare Technologies Limited, D-37/3, TTC MIDC, Turbhe, Navi Mumbai - 400 703. 9870666333 wellness@thyrocare.com

First National Diagnostic Chain to have 100% of its Labs with NABL Accreditation#

Patient Name : XXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXX

Tests Done : JAANCH ANEMIA PROFILE ADVANCED

Report Availability Summary

Note: Please refer to the table below for status of your tests.

14 Ready | **0** Ready with Cancellation | **0** Processing | **0** Cancelled in Lab

TEST DETAILS	REPORT STATUS
JAANCH ANEMIA PROFILE ADVANCED	Ready
FERRITIN	Ready
FOLATE	Ready
LACTATE DEHYDROGENASE (LDH)	Ready
RETICULOCYTE COUNT (%)	Ready
SICKLE CELL TEST	Ready
BETA-THALASSEMIA SCREENING	Ready
HEMOGRAM - 6 PART (DIFF)	Ready
LIVER FUNCTION TESTS	Ready
IRON DEFICIENCY PROFILE	Ready
KIDPRO	Ready
PERIPHERAL BLOOD SMEAR (PBS)	Ready
T3-T4-USTSH	Ready
VITAMIN D TOTAL AND B12 COMBO	Ready
ADULT HEMOGLOBIN ELECTROPHORESIS	Ready

Dummy Report

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Patient Name : XXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXX

Tests Done : JAANCH ANEMIA PROFILE ADVANCED

Tests Outside Reference Range

Note: Please refer to the table below for tests outside reference range.

Test Name	Observed Value	Units	Bio. Ref. Interval.
COMPLETE HEMOGRAM			
HEMATOCRIT(PCV)	**33.6**	%	40.0-50.0
HEMOGLOBIN	**10.4**	g/dL	13.0-17.0
LYMPHOCYTE	**17.4**	%	20-40
MEAN CORP.HEMO.CONC(MCHC)	**31**	g/dL	31.5-34.5
MEAN CORPUSCULAR HEMOGLOBIN(MCH)	**26.8**	pq	27.0-32.0
RED CELL DISTRIBUTION WIDTH (RDW-CV)	**15.4**	%	11.6-14
RED CELL DISTRIBUTION WIDTH - SD(RDW-SD)	**48.9**	fL	39-46
TOTAL RBC	**3.88**	X 10^6/µL	4.5-5.5
RENAL			
CREATININE - SERUM	**0.7**	mg/dL	0.72-1.18
VITAMIN			
25-OH VITAMIN D (TOTAL)	**11.62**	ng/mL	30-100
VITAMIN B-12	**981**	pg/mL	211-911

Dummy Report

Disclaimer: The above listed is the summary of the parameters with values outside the BRI. For detailed report values, parameter correlation and clinical interpretation, kindly refer to the same in subsequent pages.

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Patient Name	: XXXXXXXXXXXXXXX	Sample Collected on (SCT)	: XXXXXXXXXXXXXXX
Referred By	: XXXXXXXXXXXXXXX	Sample Received on (SRT)	: XXXXXXXXXXXXXXX
Sample Collected At	: XXXXXXXXXXXXXXX	Report Released on (RRT)	: XXXXXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
RETICULOCYTE COUNT (%)	MICROSCOPY	< 1.25	%

Bio. Ref. Interval. :-

Newborn (birth to 1 month of age) : 2.5 to 6.5 %
Infant (1 month to 1 year of age) : 0.5 to 3.1 %
Adult / Children / Elderly : 0.5 to 2 %

Please correlate with clinical conditions.

Method:- MICROSCOPY

Dummy Report

Tests Done : BETA-THALASSEMIA SCREENING,HEMOGLOBIN ELECTROPHORESIS,HEMOGRAM,PERIPHERAL BLOOD SMEAR,RETICULOCYTE COUNT (%),SICKLE CELL TEST

Doctor 1 Sign **Doctor 2 Sign**

Patient Name	: XXXXXXXXXXXXXXX	**Sample Collected on (SCT)**	: XXXXXXXXXXXXXXX
Referred By	: XXXXXXXXXXXXXXX	**Sample Received on (SRT)**	: XXXXXXXXXXXXXXX
Sample Collected At	: XXXXXXXXXXXXXXX	**Report Released on (RRT)**	: XXXXXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE
SICKLE CELL TEST	SOLUBILITY	NEGATIVE

Clinical Significance :-

Sickle cell disease is a collective name for a group of conditions causing clinical symptoms which are characterized by formation of sickle shaped Red Blood Cells (RBCs). The disorder is caused due to a genetic mutation involving replacement of glutamic acid by valine in position 6 of beta-chain of hemoglobin. This leads to formation of Hb S which has poor solubility in the deoxygenated state and gets polymerized within RBCs. This makes RBCs to become distorted and rigid forming sickle shape.

This test is only useful to screen the specimens for presence of Hemoglobin S. It does not differentiate between Hb S homozygous disease and sickle cell trait. A positive result must be confirmed by other techniques like electrophoresis and HPLC.

Please correlate with clinical conditions.

Dummy Report

Tests Done : BETA-THALASSEMIA SCREENING,HEMOGLOBIN ELECTROPHORESIS,HEMOGRAM,PERIPHERAL BLOOD SMEAR,RETICULOCYTE COUNT (%),SICKLE CELL TEST

Doctor 1 Sign **Doctor 2 Sign**

Patient Name : XXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXX

Sample Collected on (SCT) : XXXXXXXXXXXXXXX
Sample Received on (SRT) : XXXXXXXXXXXXXXX
Report Released on (RRT) : XXXXXXXXXXXXXXX
Sample Type | Barcode : XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
HEMOGLOBIN A2	H.P.L.C	2.7	%	2-3.5
HEMOGLOBIN F	H.P.L.C	0.5	%	< 2
HEMOGLOBIN C	H.P.L.C	Not Detected	-	--
HEMOGLOBIN D	H.P.L.C	Not Detected	-	--
HEMOGLOBIN S	H.P.L.C	Not Detected	-	--

CLINICAL INFORMATION : THALASSEMIA SYNDROME

The Thalassaemia syndromes are a heterogeneous group of inherited conditions characterized by defects in the synthesis of one or more of the globin chains that form the hemoglobin tetramer. The clinical syndromes associated with thalassaemia arise from the combined consequences of the inadequate hemoglobin production and of unbalanced accumulation of one type of globin chain. The former causes anemia with hypochromia and microcytosis; the latter leads to ineffective erythropoiesis and haemolysis. Clinical manifestations range from completely asymptomatic microcytosis to profound anemia which is incompatible with life and can cause death in utero. The laboratory diagnosis of hemoglobinopathies and thalassemias is of growing importance, particularly because of an increasing requirement for antenatal diagnosis of significant disorders of globin chain synthesis. It has been recommended that all individuals of all ethnic groups except Northern European Caucasians be screened for variant hemoglobin's, all ethnic groups for β-thalassemia trait, and selected ethnic groups for α-thalassemia trait. Family studies can be of considerable importance in elucidating the nature of disorders of hemoglobin synthesis, but definite identification can be achieved only by DNA analysis or amino acid sequencing.

PERFORMANCE SPECIFICATIONS:Intra assay precision as low as 0.6% for HBF% and 1.0% for HbA2% and inter assay precision as low as 1.4% for HBF% and 1.9% for HbA2%. .

Please Correlate with clinical conditions.

Method :- FULLY AUTOMATED HPLC USING BIO-RAD VARIANT II

Dummy Report

Tests Done : **BETA-THALASSEMIA SCREENING,HEMOGLOBIN ELECTROPHORESIS,HEMOGRAM,PERIPHERAL BLOOD SMEAR,RETICULOCYTE COUNT (%),SICKLE CELL TEST**

Doctor 1 Sign **Doctor 2 Sign**

Patient Name : XXXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXXX

Sample Collected on (SCT) : XXXXXXXXXXXXXXXX
Sample Received on (SRT) : XXXXXXXXXXXXXXXX
Report Released on (RRT) : XXXXXXXXXXXXXXXX
Sample Type | Barcode : XXXXXXXXXXXXXXXX

TEST NAME	METHODOLOGY	VALUE	UNITS	Bio. Ref. Interval.
HEMOGLOBIN	**SLS-Hemoglobin Method**	**10.4**	**g/dL**	**13.0-17.0**
Hematocrit (PCV)	**CPH Detection**	**33.6**	**%**	**40.0-50.0**
Total RBC	**HF & EI**	**3.88**	**X 10^6/µL**	**4.5-5.5**
Mean Corpuscular Volume (MCV)	Calculated	86.6	fL	83.0-101.0
Mean Corpuscular Hemoglobin (MCH)	**Calculated**	**26.8**	**pq**	**27.0-32.0**
Mean Corp.Hemo. Conc (MCHC)	**Calculated**	**31**	**g/dL**	**31.5-34.5**
Red Cell Distribution Width - SD (RDW-SD)	**Calculated**	**48.9**	**fL**	**39-46**
Red Cell Distribution Width (RDW - CV)	**Calculated**	**15.4**	**%**	**11.6-14**
RED CELL DISTRIBUTION WIDTH INDEX (RDWI)	Calculated	343.7	-	*Refer Note below
MENTZER INDEX	Calculated	22.3	-	*Refer Note below
TOTAL LEUCOCYTE COUNT (WBC)	HF & FC	7.77	X 10^3 / µL	4.0 - 10.0
DIFFERENTIAL LEUCOCYTE COUNT				
Neutrophils Percentage	Flow Cytometry	75.2	%	40-80
Lymphocytes Percentage	**Flow Cytometry**	**17.4**	**%**	**20-40**
Monocytes Percentage	Flow Cytometry	2.7	%	2-10
Eosinophils Percentage	Flow Cytometry	3.9	%	1-6
Basophils Percentage	Flow Cytometry	0.5	%	0-2
Immature Granulocyte Percentage (IG%)	Flow Cytometry	0.3	%	0-0.5
Nucleated Red Blood Cells %	Flow Cytometry	0.1	%	0.0-5.0
ABSOLUTE LEUCOCYTE COUNT				
Neutrophils - Absolute Count	Calculated	5.84	X 10^3 / µL	2.0-7.0
Lymphocytes - Absolute Count	Calculated	1.35	X 10^3 / µL	1.0-3.0
Monocytes - Absolute Count	Calculated	0.21	X 10^3 / µL	0.2 - 1.0
Basophils - Absolute Count	Calculated	0.04	X 10^3 / µL	0.02 - 0.1
Eosinophils - Absolute Count	Calculated	0.3	X 10^3 / µL	0.02 - 0.5
Immature Granulocytes (IG)	Calculated	0.02	X 10^3 / µL	0-0.3
Nucleated Red Blood Cells	Calculated	0.01	X 10^3 / µL	0.0-0.5
PLATELET COUNT	HF & EI	260	X 10^3 / µL	150-410
Mean Platelet Volume (MPV)	Calculated	10.3	fL	6.5-12
Platelet Distribution Width (PDW)	Calculated	11.2	fL	9.6-15.2
Platelet to Large Cell Ratio (PLCR)	Calculated	26.6	%	19.7-42.4
Plateletcrit (PCT)	Calculated	0.27	%	0.19-0.39

***Note - Mentzer index (MI), RDW-CV and RDWI are hematological indices to differentiate between Iron Deficiency Anemia(IDA) and Beta Thalassemia Trait (BTT). MI >13, RDWI >220 and RDW-CV >14 more likely to be IDA. MI <13, RDWI <220, and RDW-CV <14 more likely to be BTT. Suggested Clinical correlation. BTT to be confirmed with HB electrophoresis if clinically indicated**

Method : Fully automated bidirectional analyser (6 Part Differential SYSMEX XN-1000)

(Reference : *FC- flowcytometry, *HF- hydrodynamic focussing, *EI- Electric Impedence, *Hb- hemoglobin, *CPH- Cumulative pulse height**)**

Tests Done : **BETA-THALASSEMIA SCREENING,HEMOGLOBIN ELECTROPHORESIS,HEMOGRAM,PERIPHERAL BLOOD SMEAR,RETICULOCYTE COUNT (%),SICKLE CELL TEST**

Doctor 1 Sign **Doctor 2 Sign**

Dummy Report

Patient Name	: XXXXXXXXXXXXXXX	**Sample Collected on (SCT)**	: XXXXXXXXXXXXXXX
Referred By	: XXXXXXXXXXXXXXX	**Sample Received on (SRT)**	: XXXXXXXXXXXXXXX
Sample Collected At	: XXXXXXXXXXXXXXX	**Report Released on (RRT)**	: XXXXXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXXXXX

TEST NAME	METHOD
PERIPHERAL BLOOD SMEAR (PBS)	MICROSCOPY

RBCs : Predominantly normocytic normochromic.

WBCs : Predominantly normocytic normochromic.

PLATELET : Predominantly normocytic normochromic.

CLINICAL REMARKS : Predominantly normocytic normochromic.

TECHNOLOGY : MICROSCOPY

Please correlate with clinical conditions

Dummy Report

Tests Done : BETA-THALASSEMIA SCREENING,HEMOGLOBIN ELECTROPHORESIS,HEMOGRAM,PERIPHERAL BLOOD SMEAR,RETICULOCYTE COUNT (%),SICKLE CELL TEST

Doctor 1 Sign **Doctor 2 Sign**

Patient Name : XXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXX

Sample Collected on (SCT) : XXXXXXXXXXXXXXX
Sample Received on (SRT) : XXXXXXXXXXXXXXX
Report Released on (RRT) : XXXXXXXXXXXXXXX
Sample Type | Barcode : XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
25-OH VITAMIN D (TOTAL)	**C.L.I.A**	**11.62**	**ng/mL**

Bio. Ref. Interval. :
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**	**981**	**pg/mL**

Bio. Ref. Interval. :

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

Tests Done : JAANCH ANEMIA PROFILE ADVANCED

Doctor 1 Sign Doctor 2 Sign

Patient Name : XXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXX

Sample Collected on (SCT) : XXXXXXXXXXXXXXX
Sample Received on (SRT) : XXXXXXXXXXXXXXX
Report Released on (RRT) : XXXXXXXXXXXXXXX
Sample Type | Barcode : XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
FOLATE	C.L.I.A	< 18.4	ng/mL

Bio. Ref. Interval. :
> 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 | Barcode : XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
FERRITIN	C.L.I.A	< 215	ng/mL
Bio. Ref. Interval. : Men: 22-322 ng/ml Women: 10-291 ng/ml **Method :** Fully Automated Bidirectionally Interfaced Chemi Luminescent Immuno Assay			
IRON	PHOTOMETRY	98	µg/dL
Bio. Ref. Interval. : Male : 65 - 175 Female : 50 - 170 **Method :** Ferrozine method without deproteinization			
TOTAL IRON BINDING CAPACITY (TIBC)	PHOTOMETRY	334	µg/dL
Bio. Ref. Interval. : Male: 225 - 535 µg/dl Female: 215 - 535 µg/dl **Method :** Spectrophotometric Assay			
% TRANSFERRIN SATURATION	CALCULATED	29	%
Bio. Ref. Interval. : 13 - 45 **Method :** Derived from IRON and TIBC values			
UNSAT.IRON-BINDING CAPACITY(UIBC)	PHOTOMETRY	236.2	µg/dL
Bio. Ref. Interval. : 162 - 368 **Method :** SPECTROPHOTOMETRIC ASSAY			

Please correlate with clinical conditions.

Dummy Report

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Sample Collected At : XXXXXXXXXXXXXXX

Sample Collected on (SCT) : XXXXXXXXXXXXXXX
Sample Received on (SRT) : XXXXXXXXXXXXXXX
Report Released on (RRT) : XXXXXXXXXXXXXXX
Sample Type | Barcode : XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
ALKALINE PHOSPHATASE	PHOTOMETRY	105.1	U/L	45-129
BILIRUBIN - TOTAL	PHOTOMETRY	0.45	mg/dL	0.3-1.2
BILIRUBIN -DIRECT	PHOTOMETRY	0.14	mg/dL	< 0.3
BILIRUBIN (INDIRECT)	CALCULATED	0.31	mg/dL	0-0.9
GAMMA GLUTAMYL TRANSFERASE (GGT)	PHOTOMETRY	13.4	U/L	< 55
ASPARTATE AMINOTRANSFERASE (SGOT)	PHOTOMETRY	24.3	U/L	< 35
ALANINE TRANSAMINASE (SGPT)	PHOTOMETRY	32.9	U/L	< 45
SGOT / SGPT RATIO	CALCULATED	0.74	Ratio	< 2
PROTEIN - TOTAL	PHOTOMETRY	6.98	gm/dL	5.7-8.2
ALBUMIN - SERUM	PHOTOMETRY	4.14	gm/dL	3.2-4.8
SERUM GLOBULIN	CALCULATED	2.84	gm/dL	2.5-3.4
SERUM ALB/GLOBULIN RATIO	CALCULATED	1.46	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
GGT - Modified IFCC method
SGOT - IFCC* Without Pyridoxal Phosphate Activation
SGPT - IFCC* Without Pyridoxal Phosphate Activation
OT/PT - Derived from SGOT and SGPT values.
PROT - Biuret Method
SALB - Albumin Bcg[1]method (Colorimetric Assay Endpoint)
SEGB - DERIVED FROM SERUM ALBUMIN AND PROTEIN VALUES
A/GR - Derived from serum Albumin and Protein values

Dummy Report

Tests Done : **JAANCH ANEMIA PROFILE ADVANCED**

Doctor 1 Sign **Doctor 2 Sign**

Patient Name	: XXXXXXXXXXXXXXX	Sample Collected on (SCT)	: XXXXXXXXXXXXXXX
Referred By	: XXXXXXXXXXXXXXX	Sample Received on (SRT)	: XXXXXXXXXXXXXXX
Sample Collected At	: XXXXXXXXXXXXXXX	Report Released on (RRT)	: XXXXXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
LACTATE DEHYDROGENASE (LDH)	PHOTOMETRY	< 185	U/L

Bio. Ref. Interval. :-

120-250

Clinical Significance:
Lactate Dehydrogenase occurs in the cytoplasm of all cells;there are five isoenzymes. The highest concentration are found in heart,liver,skeletal muscle,kidney, and the RBCs,with lesser amounts in lung,smooth muscle, and brain . LD catalyzes the interconversion of lactate and pyruvate. Marked elevations in lactate dehydrogenase (LD) activity can be observed in megaloblastic anemia, untreated pernicious anemia, Hodgkins disease, abdominal and lung cancers, severe shock, and hypoxia. Moderate to slight increases in LD levels are seen in myocardial infarction (MI), pulmonary infarction, pulmonary embolism, leukemia, hemolytic anemia, infectious mononucleosis, progressive muscular dystrophy (especially in the early and middle stages of the disease), liver disease, and renal disease. In liver disease, elevations of LD are not as great as the increases in aspartate amino transferase (AST) and alanine aminotransferase (ALT). Increased levels of the enzyme are found in about one third of patients with renal disease, especially those with tubular necrosis or pyelonephritis. However, these elevations do not correlate well with proteinuria or other parameters of renal disease. On occasion a raised LD level may be the only evidence to suggest the presence of a hidden pulmonary embolus.

Specifications: Precision: Intra assay (%CV): 0.76, Inter assay (%CV): 1.8, Sensitivity: >=0.01

Kit validation references:

Amador E. Dorfman L. E. Wacker W. E., Clin. Chem., 1963; 331

Please correlate with clinical conditions.
Method:- LACTATE / NAD METHOD

Dummy Report

Tests Done : JAANCH ANEMIA PROFILE ADVANCED

Doctor 1 Sign **Doctor 2 Sign**

Patient Name : XXXXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXXXX
Sample Collected At : XXXXXXXXXXXXXXX

Sample Collected on (SCT) : XXXXXXXXXXXXXXX
Sample Received on (SRT) : XXXXXXXXXXXXXXX
Report Released on (RRT) : XXXXXXXXXXXXXXX
Sample Type | Barcode : XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
BLOOD UREA NITROGEN (BUN)	PHOTOMETRY	12.6	mg/dL	7.94 - 20.07
CREATININE - SERUM	**PHOTOMETRY**	**0.7**	**mg/dL**	**0.72-1.18**
BUN / Sr.CREATININE RATIO	CALCULATED	18	Ratio	9:1-23:1
UREA (CALCULATED)	CALCULATED	26.96	mg/dL	Adult : 17-43
UREA / SR.CREATININE RATIO	CALCULATED	38.52	Ratio	< 52
CALCIUM	PHOTOMETRY	9.62	mg/dL	8.8-10.6
URIC ACID	PHOTOMETRY	6.8	mg/dL	4.2 - 7.3

Please correlate with clinical conditions.

Method :

BUN - Kinetic UV Assay.
SCRE - Creatinine Enzymatic Method
B/CR - Derived from serum Bun and Creatinine values
UREAC - Derived from BUN Value.
UR/CR - Derived from UREA and Sr.Creatinine values.
CALC - Arsenazo III Method, End Point.
URIC - Uricase / Peroxidase Method

Dummy Report

Tests Done : **JAANCH ANEMIA PROFILE ADVANCED**

Doctor 1 Sign **Doctor 2 Sign**

Patient Name	: XXXXXXXXXXXXXXX	**Sample Collected on (SCT)**	: XXXXXXXXXXXXXXX
Referred By	: XXXXXXXXXXXXXXX	**Sample Received on (SRT)**	: XXXXXXXXXXXXXXX
Sample Collected At	: XXXXXXXXXXXXXXX	**Report Released on (RRT)**	: XXXXXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TOTAL TRIIODOTHYRONINE (T3)	C.L.I.A	79	ng/dL	60-200
TOTAL THYROXINE (T4)	C.L.I.A	6.4	µg/dL	4.5-12
TSH - ULTRASENSITIVE	C.M.I.A	<2.92	µIU/mL	0.35-4.94

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 - Fully Automated Chemi Luminescent Microparticle Immunoassay

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. To diagnose and monitor therapy doses, it is recommended to get tested every time at the same Laboratory.

Dummy Report

Tests Done : JAANCH ANEMIA PROFILE ADVANCED

Doctor 1 Sign **Doctor 2 Sign**

Patient Name	: XXXXXXXXXXXXXXX	Sample Collected on (SCT)	: XXXXXXXXXXXXXXX
Referred By	: XXXXXXXXXXXXXXX	Sample Received on (SRT)	: XXXXXXXXXXXXXXX
Sample Collected At	: XXXXXXXXXXXXXXX	Report Released on (RRT)	: XXXXXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
EST. GLOMERULAR FILTRATION RATE (eGFR)	CALCULATED	134	mL/min/1.73 m2

Bio. Ref. Interval. :-

> = 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:- 2021 CKD EPI Creatinine Equation

~~ End of report ~~

Dummy Report

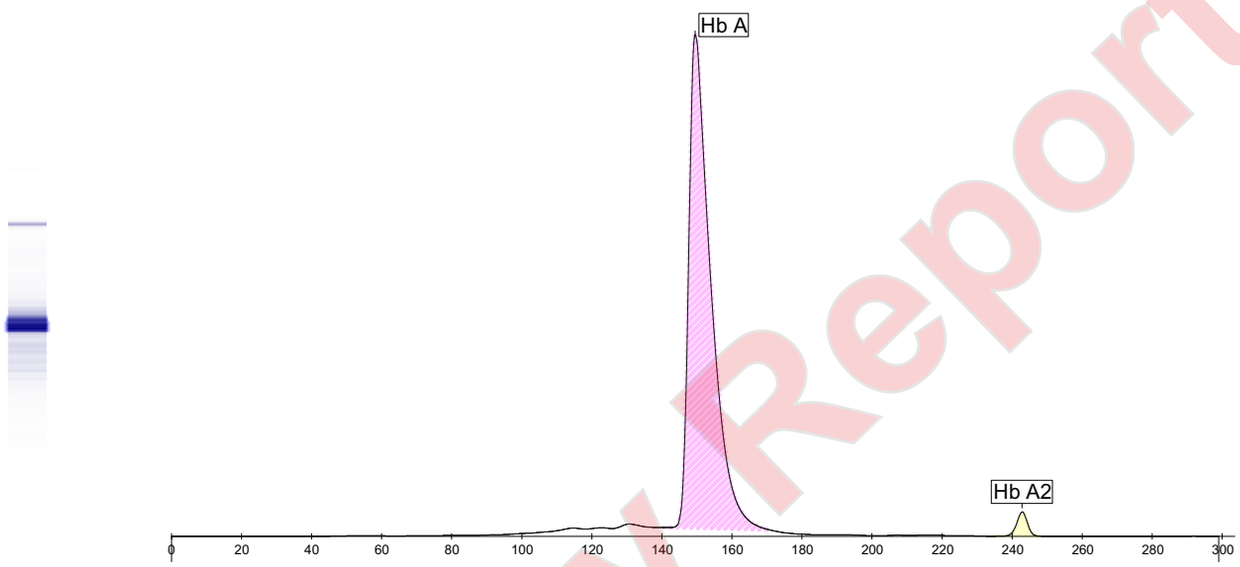
Tests Done : JAANCH ANEMIA PROFILE ADVANCED

Doctor 1 Sign **Doctor 2 Sign**

NAME : XXXXXXXXX
REF. BY : XXXXXXXXX

DATE : XXXXXXXXXX
LABCODE:
BARCODE : XXXXXXXXXX

Haemoglobin Electrophoresis



Name	%
Hb A	**97.5**
Hb A2	**2.5**

REFERENCE RANGE: Adults - Hb A = 96.8 - 97.8% Hb F = 0.0 - 0.5 % Hb A2 = 2.2 - 3.2 %

COMMENTS :

TECHNOLOGY : Fully automated Capillary Zone Electrophoresis (Sebia Capillarys 3 OCTA).

Doctor 1 Sign **Doctor 2 Sign**

Dummy Report

CONDITIONS OF REPORTING

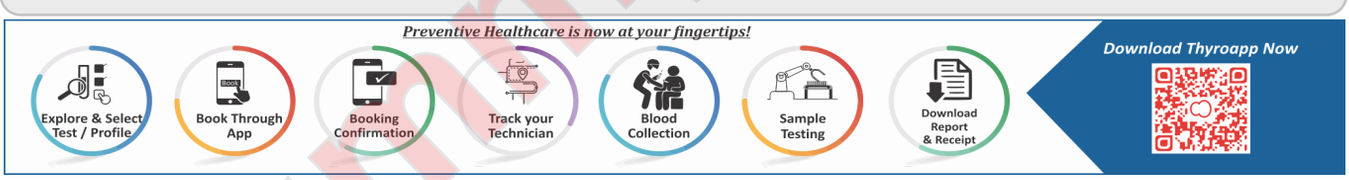
- The reported results are for information and interpretation of the referring doctor only.
- It is presumed that the tests performed on the specimen belong to the patient; named or identified.
- Results of tests may vary from laboratory to laboratory and also in some parameters from time to time for 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: (a) 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, (b) any claims of any nature whatsoever arising from or relating to the performance of the requested tests as well as any claim for indirect, incidental or consequential damages. The total liability, in any case, of Thyrocare shall not exceed the total amount of invoice for the services provided and paid for.
- Thyrocare Discovery video link :- https://youtu.be/nbdYeRgYyQc

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, clinical support or feedback, write to us at **customersupport@thyrocare.com** or call us on **022-3090 0000**





+ T&C Apply, #As on 5th December 2024 (Applicable for all company owned labs except Bhagalpur & Vijayawada),

⋆ As per survey on doctors' perception of laboratory diagnostics (IJARIIT, 2023), -Mumbai Reference Lab is CAP Accredited

Dummy Report