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REPORT

NAME : XXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN A	LC-MS/MS	371.91	ng/mL

Reference Range :-

Age	Reference range
1 - 6 Years	200 - 400
7 - 12 Years	260 - 490
13 - 19 Years	260 - 720
Above 18 Years	300 - 800

Clinical Significance:

Vitamin A or Retinol plays important role in the function retinal vision, growth, reproduction, embryonic development as well as in immune function. Vitamin A is also required for adaptive immunity and plays a role in the development of both T- helper cells and B-cells. Retinol and its metabolites and synthetic retinoids provide protective effects against the development of certain types of cancer by blocking tumor promotion, by inhibiting proliferation, by inducing apoptosis, by inducing differentiation or by performing combination of these actions.

Fat malabsorption, particularly caused by celiac disease or chronic pancreatitis and protein -energy malnutrition predispose to vitamin A deficiency. Clinical features of vitamin A deficiency include degenerative changes in eyes and skin and poor dark adaptation or night blindness. Vitamin A deficiency impairs innate immunity by impeding normal regeneration of mucosal bariers damaged by infection and by diminishing the function of neutrophils, macrophages and natural killer cells.

Toxic effects of hypervitaminosis A have occurred as a result of ingestion of excess vitamin or as a side effect of inappropriate therapy. Symptoms of acute toxicity from single massive dose present as abdominal pain, nausea,, vomiting, severe headache, dizziness, sluggishness and irritability. Chronic toxicity shows symptoms like bone, join pain, hair loss, dryness and fissures of the lips, anorexia, benign intracranial hypertension, weight loss an hepatomegaly.

Clinical reference:

Tietz Textbok of clinical chemistry and Molecular diagnostic, Carl A. Burtis, Edward R. Ashwood, David E. Bruns, Fifth edition., Elsevier.

Please correlate with clinical conditions.

Method:- LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

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

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REF. BY : XXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN E	LC-MS/MS	14769.1	ng/mL

Reference Range :-

Age
< 1 Month 1000 - 3500
2 - 5 Months 2000 - 6000
6 M - 1 year 3500 - 8000
2 - 12 years 5500 - 9000
Above 13 years 5500 - 18000

Clinical Significance: Vitamin E or Alpha-tocopherol (body's main form of vitamin) function as antioxidant which protects vitamin A, C and red blood cells from oxidative damage caused by free radicals. It has been recognized as necessary for neurologic and reproductive functions, for prevention of retinopathy in premature infants. Alpha-tocopherol also induces inhibition of cell proliferation, platelete aggregation, and monocyte adhesion, which are thought to be the results of direct interaction of alpha-tocopherol with cell components. Alpha-tocopherol reduces inflammatory mediator production.

Premature and low birth weight infants are particularly susceptible to development of vitamin E deficiency, because placental transfer is poor and infants have such limited adipose tissue where much of the vitamins is normally stored. Signs of deficiency include irritability, edema and hemolytic anemia. Although symptoms of vitamin E deficiency are rare in children and adults, deficiency can occur in some conditions.

Excess vitamin E intake usually is achieved only by dietary supplementation. A comprehensive review of tolerance and safety of vitamin E suggested that intakes upto 3000mg/d were safe and reversible side effects of gastrointestinal symptoms, increased creatinuria, and impairment of blood coagulation are seen at intakes of 1000-3000 mg/d. However as noted earlier, long term use of intakes greater than 400mg/d may cause increased mortality.

Clinical reference: Tietz Textbok of clinical chemistry and Molecular diagnostic, Carl A. Burtis, Edward R. Ashwood, David E. Bruns, Fifth edition., Elsevier.

Please correlate with clinical conditions.

Method:- LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

Dummy Report

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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN K	LC-MS/MS	0.27	ng/mL

Reference Range :-

0.13 - 1.19

Clinical significance:

Vitamin K assay measures the principal form of vitamin K i.e. K1 :Phylloquinone which found predominantly in green leafy vegetables, margarines and plant oils.

Vitamin K promotes clotting of the blood, is required for the conversion of several clotting factors and prothombin, and is of growing interest in bone metabolism. Vitamin K plays important role in the deposition of ionic calcium needed for proper blood coagulation and bone formation.

Although vitamin K deficiency in the adults is uncommon, the risk is increased for fat malabsorption states such as bile duct obstruction,cystic fibrosis, chronic pancreatitis and liver disease. Risk also increased by the use of drugs that interfere with vitamin K metabolism, such as warfarin, cepahlosporin. Defective blood coagulation and demonstration of abnormal noncarboxylated prothrombin are at present the only well-established signs of vitamin K deficiency.

The use of high doses of naturally occurring vitamin K (K1 and K2) appears to have no untoward effect; however menadione(K3) treatment can lead to formation of erythrocyte cytoplasmic inclusions known as Heinz bodies and hemolytic anemia. With severe hemolysis, increase bilirubin formation and undeveloped capacity for its conjugation may produce kernicterus in the newborn.

Clinical reference:

Tietz Textbok of clinical chemistry and Molecular diagnostic, Carl A. Burtis, Edward R. Ashwood, David E. Bruns, Fifth edition., Elsevier.

Please correlate with clinical conditions.

Method:- LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

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REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

PATIENTID :

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	NORMAL RANGE
VITAMIN B1/THIAMIN	LC-MS/MS	1.97	ng/mL	0.5-4.0
VITAMIN B2/RIBOFLAVIN	LC-MS/MS	13.91	ng/mL	1.6-68.2
VITAMIN B3/NICOTINIC ACID	LC-MS/MS	1.51	ng/mL	0.3-9.8
VITAMIN B5/PANTOTHENIC	LC-MS/MS	41.44	ng/mL	11-150
VITAMIN B6/P5P	LC-MS/MS	6.84	ng/mL	5 - 50
VITAMIN B7/BIOTIN	LC-MS/MS	0.34	ng/mL	0.2-3
VITAMIN B9/FOLIC ACID	LC-MS/MS	0.64	ng/mL	0.2-20
VITAMIN B-12	E.C.L.I.A	290	pg/mL	197-771

Please correlate with clinical conditions.

Method :

VITB1 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB2 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB3 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB5 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB6 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB7 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB9 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB - Fully Automated Electrochemiluminescence Compitive Immunoassay

Dummy Report

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

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REF. BY : XXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
ALPHA-1-ANTITRYPSIN (AAT)	IMMUNOTURBIDIMETRY	134.83	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

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Report Released on (RRT) : Report release time
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Labcode :
Barcode :

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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
HOMOCYSTEINE	PHOTOMETRY	17.29	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
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

NAME : XXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
ANTI NUCLEAR ANTIBODIES (ANA)	E.L.I.S.A	14.92	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

ANTI CCP (ACCP)	E.L.I.S.A	5	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

Please correlate with clinical conditions.

Dummy Report

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REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
CYSTATIN C	IMMUNOTURBIDIMETRY	0.72	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
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

NAME : XXXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
APOLIPOPROTEIN - A1 (APO-A1)	IMMUNOTURBIDIMETRY	140	mg/dL

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

APOLIPOPROTEIN - B (APO-B)	IMMUNOTURBIDIMETRY	87	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	0.6	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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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	IMMUNOTURBIDIMETRY	1.99	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

Sample Collected on (SCT) : Sample collection time
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Labcode :
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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
FERRITIN	E.C.L.I.A	28	ng/mL

Reference Range :-

Men: 20-60 yrs : 30-400 ng/ml
Women: 17-60 yrs : 13-150 ng/ml

Please correlate with clinical conditions.

Method:- Fully Automated Electrochemiluminescence Sandwich Immunoassay

Dummy Report

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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
INSULIN - FASTING	C.L.I.A	7.58	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

Sample Collected on (SCT) : Sample collection time
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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
BLOOD KETONE (D3HB)	PHOTOMETRY	0.44	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.

Please correlate with clinical conditions.
Method:- ENZYMATIC (KINETIC)

Dummy Report

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Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
FRUCTOSAMINE	PHOTOMETRY	211.71	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.

Please correlate with clinical conditions.
Method:- NITROBLUE TETRAZOLIUM ASSAY (NBT)

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 : XXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
Lipoprotein (a) [Lp(a)]	**IMMUNOTURBIDIMETRY**	**53.7**	**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
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

NAME : XXXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
LP-PLA2	PHOTOMETRY	126	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 :

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REPORT

NAME : XXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
SERUM COPPER	PHOTOMETRY	128.84	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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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
SERUM ZINC	PHOTOMETRY	80.11	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

Sample Collected on (SCT) : Sample collection time
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Sample Type : SERUM
Labcode :
Barcode :

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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
TESTOSTERONE	E.C.L.I.A	34.7	ng/dL

Reference Range :-

Males
20-49 yrs: 249-836 ng/dL
>=50 yrs : 193-740 ng/dL
Females
20-49 yrs : 8.4 - 48.1 ng/dL
>=50 yrs : 2.9 - 40.8 ng/dL

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): 11.50 %, Inter assay (%CV): 5.70%; Sensitivity: 7 ng/dL.

Kit Validation Reference: Wilson JD Foster DW (Eds) Williams Textbook of Endocrinology 8th Edition WB Saunders Piladelphia Pennsylvania .

Please correlate with clinical conditions.
Method:- Fully Automated Electrochemiluminescence Compititive Immunoassay

Dummy Report

Sample Collected on (SCT) : Sample collection time
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TEST ASKED : AAROGYAM X WITH UTSH

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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
AMYLASE	PHOTOMETRY	57	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

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

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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
IRON	PHOTOMETRY	56.8	µg/dL
Reference Range : Male : 65 - 175 Female : 50 - 170 **Method :** FERROZINE METHOD WITHOUT DEPROTEINIZATION			
TOTAL IRON BINDING CAPACITY (TIBC)	PHOTOMETRY	276.4	µg/dL
Reference Range : Male: 225 - 535 µg/dl Female: 215 - 535 µg/dl **Method :** SPECTROPHOTOMETRIC ASSAY			
% TRANSFERRIN SATURATION	CALCULATED	20.55	%
Reference Range : 13 - 45 **Method :** DERIVED FROM IRON AND TIBC VALUES			
UNSAT.IRON-BINDING CAPACITY(UIBC)	PHOTOMETRY	219.6	µg/dL
Reference Range : 162 - 368 **Method :** SPECTROPHOTOMETRIC ASSAY			

Please correlate with clinical conditions.

Dummy Report

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Sample Type : SERUM
Labcode :
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SAMPLE COLLECTED AT :
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PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
LIPASE	PHOTOMETRY	41	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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Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

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TEST ASKED : AAROGYAM X WITH UTSH

PATIENTID :

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	NORMAL RANGE
TOTAL CHOLESTEROL	PHOTOMETRY	194	mg/dL	< 200
HDL CHOLESTEROL - DIRECT	PHOTOMETRY	56	mg/dL	40-60
HDL / LDL RATIO	CALCULATED	0.48	Ratio	> 0.40
LDL CHOLESTEROL - DIRECT	**PHOTOMETRY**	**119**	**mg/dL**	**< 100**
TC/ HDL CHOLESTEROL RATIO	CALCULATED	3.4	Ratio	3 - 5
TRIG / HDL RATIO	CALCULATED	0.93	Ratio	< 3.12
LDL / HDL RATIO	CALCULATED	2.1	Ratio	1.5-3.5
TRIGLYCERIDES	PHOTOMETRY	52	mg/dL	< 150
VLDL CHOLESTEROL	CALCULATED	10.43	mg/dL	5 - 40
NON-HDL CHOLESTEROL	CALCULATED	137.3	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
TC/H - DERIVED FROM SERUM CHOLESTEROL AND HDL VALUES
TRI/H - Derived from TRIG and HDL Values
LDL/ - DERIVED FROM SERUM HDL AND LDL VALUES
TRIG - Enzymatic, End Point
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.

Dummy Report

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

Doctor 1 Sign Doctor 2 Sign

REPORT

NAME : XXXXXXXXXXXXXXXXX
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TEST ASKED : AAROGYAM X WITH UTSH

PATIENTID :

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	NORMAL RANGE
ALKALINE PHOSPHATASE	PHOTOMETRY	82.2	U/L	45-129
BILIRUBIN - TOTAL	PHOTOMETRY	0.35	mg/dL	0.3-1.2
BILIRUBIN -DIRECT	PHOTOMETRY	0.07	mg/dL	< 0.3
BILIRUBIN (INDIRECT)	CALCULATED	0.28	mg/dL	0-0.9
GAMMA GLUTAMYL TRANSFERASE (GGT)	PHOTOMETRY	15.4	U/L	< 38
SGOT / SGPT RATIO	CALCULATED	1.28	Ratio	< 2
ASPARTATE AMINOTRANSFERASE (SGOT)	PHOTOMETRY	20.1	U/L	< 31
ALANINE TRANSAMINASE (SGPT)	PHOTOMETRY	15.7	U/L	< 34
PROTEIN - TOTAL	PHOTOMETRY	6.81	gm/dL	5.7-8.2
ALBUMIN - SERUM	PHOTOMETRY	3.97	gm/dL	3.2-4.8
SERUM ALB/GLOBULIN RATIO	CALCULATED	1.4	Ratio	0.9 - 2
SERUM GLOBULIN	CALCULATED	2.84	gm/dL	2.5-3.4

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
OT/PT - Derived from SGOT and SGPT values.
SGOT - IFCC* WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION
SGPT - IFCC* WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION
PROT - BIURET METHOD
SALB - ALBUMIN BCG¹METHOD (COLORIMETRIC ASSAY ENDPOINT)
A/GR - DERIVED FROM SERUM ALBUMIN AND PROTEIN VALUES
SEGB - DERIVED FROM SERUM ALBUMIN AND PROTEIN VALUES

Dummy Report

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Labcode :
Barcode :

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REPORT

NAME : XXXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
MAGNESIUM	PHOTOMETRY	2.02	mg/dL

Reference Range :-

1.90 - 3.10 mg/dL

Clinical significance:

Magnesium is the fourth most abundant cation in the body and second most prevalent intracellular cation. The total body magnesium content is about 25 g or approximately 1 mol, of which 55% reside in the skeleton. About 45% of the magnesium is intracellular. In general higher the metabolic activity of cell, the greater is its magnesium content. Magnesium is a cofactor for more than 300 enzymes in the body.

Disorders of magnesium metabolism are separated into those causing hypomagnesaemia/magnesium deficiencies and hypermagnesemia. Hypomagnesaemia is common in patient in hospitals. Moderate to severe deficiency of magnesium is usually due to loss of magnesium from the gastrointestinal (gi) tract or kidneys. One of the more serious complications of magnesium deficiency is cardiac arrhythmia. Symptomatic hypermagnsemia is almost always caused by excessive intake, resulting from administration of antacids, enemas, and parenteral fluids containing magnesium. Depression of neuromuscular system is the most common manifestation of magnesium intoxication.

External quality control program participation:

College Of American Pathologists: Chemistry survey; CAP Number: 7193855-01

Please correlate with clinical conditions.
Method:- MODIFIED XYLIDYL BLUE REACTION METHOD

Dummy Report

Sample Collected on (SCT) : Sample collection time
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Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

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REF. BY : XXXXXXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS	NORMAL RANGE
CALCIUM	PHOTOMETRY	8.91	mg/dL	8.8-10.6
URIC ACID	**PHOTOMETRY**	**3.08**	**mg/dL**	**3.2 - 6.1**
UREA (CALCULATED)	**CALCULATED**	**14.53**	**mg/dL**	**Adult : 17-43**
BLOOD UREA NITROGEN (BUN)	**PHOTOMETRY**	**6.79**	**mg/dL**	**7.94 - 20.07**
UREA / SR.CREATININE RATIO	CALCULATED	27.94	Ratio	< 52
CREATININE - SERUM	**PHOTOMETRY**	**0.52**	**mg/dL**	**0.55-1.02**
BUN / SR.CREATININE RATIO	CALCULATED	13.06	Ratio	9:1-23:1
SODIUM	I.S.E	137.51	mmol/L	136 - 145
CHLORIDE	I.S.E	100.01	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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REPORT

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REF. BY : XXXXXXXXXXXXXXXXXXX

TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS	REFERENCE RANGE
TOTAL TRIIODOTHYRONINE (T3)	E.C.L.I.A	88	ng/dL	80-200
TOTAL THYROXINE (T4)	E.C.L.I.A	6.69	µg/dL	4.8-12.7
TSH - ULTRASENSITIVE	E.C.L.I.A	1.24	µIU/mL	0.54-5.30

Comments : ***

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

Method :

T3 - Fully Automated Electrochemiluminescence Compititive Immunoassay
T4 - Fully Automated Electrochemiluminescence Compititive Immunoassay
USTSH - Fully Automated Electrochemiluminescence Sandwich Immunoassay

Pregnancy reference ranges for TSH/USTSH :
Trimester || T3 (ng/dl) || T4 (µg/dl) || TSH/USTSH (µIU/ml)
1st || 83.9-196.6 || 4.4-11.5 || 0.1-2.5
2nd || 86.1-217.4 || 4.9-12.2 || 0.2-3.0
3rd || 79.9-186 || 5.1-13.2 || 0.3-3.5

References :

1. Carol Devilia, C I Parhon. First Trimester Pregnancy ranges for Serum TSH and Thyroid Tumor reclassified as Benign. Acta Endocrinol. 2016; 12(2) : 242 - 243
2. Kulhari K, Negi R, Kalra DK et al. Establishing Trimester specific Reference ranges for thyroid hormones in Indian women with normal pregnancy : New light through old window. Indian Journal of Contemporary medical research. 2019; 6(4)

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

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TEST ASKED : AAROGYAM X WITH UTSH

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
EST. GLOMERULAR FILTRATION RATE (eGFR)	CALCULATED	121	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

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SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN D2	LC-MS/MS	1.19	ng/mL
Method : LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY			
VITAMIN D3	LC-MS/MS	16.23	ng/mL
Method : LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY			
VITAMIN D TOTAL	**LC-MS/MS**	**17.42**	**ng/mL**

Reference Range :
Deficiency : <20 ng/mL
Insufficiency : 20-30 ng/mL
Sufficiency : 30-100 ng/mL
Toxicity : >100 ng/mL

Method : LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

Please correlate with clinical conditions.

Dummy Report

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022 - 3090 0000 / 6712 3400 9870666333 wellness@thyrocare.com www.thyrocare.com

REPORT

NAME : XXXXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXXX
TEST ASKED : ELEMENTS 22 (TOXIC AND NUTRIENTS),HbA1c,HEMOGRAM
PATIENTID :

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	NORMAL RANGE
ARSENIC	ICP-MS	0.59	µg/L	< 5
CADMIUM	ICP-MS	0.45	µg/L	< 1.5
MERCURY	ICP-MS	0.27	µg/L	< 5
LEAD	ICP-MS	48.41	µg/L	< 150
CHROMIUM	ICP-MS	4.08	µg/L	< 30
BARIUM	ICP-MS	1.61	µg/L	< 30
COBALT	ICP-MS	0.54	µg/L	0.10 - 1.50
CAESIUM	ICP-MS	2.23	µg/L	< 5
THALLIUM	ICP-MS	0.03	µg/L	< 1
URANIUM	ICP-MS	0.04	µg/L	< 1
STRONTIUM	ICP-MS	19.87	µg/L	8 - 38
ANTIMONY	ICP-MS	9.38	µg/L	0.10 - 18
TIN	ICP-MS	0.81	µg/L	< 2
MOLYBDENUM	ICP-MS	2.81	µg/L	0.70 - 4.0
SILVER	ICP-MS	1.46	µg/L	< 4
VANADIUM	ICP-MS	0.54	µg/L	< 0.8
BERYLLIUM	**ICP-MS**	**0.04**	**µg/L**	**0.10 - 0.80**
BISMUTH	ICP-MS	0.14	µg/L	0.10 - 0.80
SELENIUM	ICP-MS	173.53	µg/L	60 - 340
ALUMINIUM	ICP-MS	15.88	µg/L	< 30
NICKEL	ICP-MS	1.78	µg/L	< 15
MANGANESE	ICP-MS	13.78	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 :

Doctor 1 Sign Doctor 2 Sign

REPORT

NAME : XXXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXX
TEST ASKED : ELEMENTS 22 (TOXIC AND NUTRIENTS),HbA1c,HEMOGRAM
PATIENTID :

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
HbA1c - (HPLC - NGSP Certified)			
	H.P.L.C	5.4	%

Reference Range :

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

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

AVERAGE BLOOD GLUCOSE (ABG)	CALCULATED	108	mg/dL

Reference Range :

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

Method : Derived from HBA1c values

Please correlate with clinical conditions.

Dummy Report

Sample Collected on (SCT) : Sample collection time
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Sample Type : EDTA
Labcode :
Barcode :

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REPORT

NAME : XXXXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXXXXX
TEST ASKED : ELEMENTS 22 (TOXIC AND NUTRIENTS),HbA1c,HEMOGRAM
PATIENTID :

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	VALUE	UNITS	REFERENCE RANGE
TOTAL LEUCOCYTES COUNT (WBC)	6	X 10³ / µL	4.0 - 10.0
NEUTROPHILS	**82**	**%**	**40-80**
LYMPHOCYTE PERCENTAGE	**15.5**	**%**	**20-40**
MONOCYTES	**1.5**	**%**	**2-10**
EOSINOPHILS	**0.5**	**%**	**1-6**
BASOPHILS	0.2	%	0-2
IMMATURE GRANULOCYTE PERCENTAGE(IG%)	0.3	%	0.0-0.4
NEUTROPHILS - ABSOLUTE COUNT	4.92	X 10³ / µL	2.0-7.0
LYMPHOCYTES - ABSOLUTE COUNT	**0.93**	**X 10³ / µL**	**1.0-3.0**
MONOCYTES - ABSOLUTE COUNT	**0.09**	**X 10³ / µL**	**0.2 - 1.0**
BASOPHILS - ABSOLUTE COUNT	**0.01**	**X 10³ / µL**	**0.02 - 0.1**
EOSINOPHILS - ABSOLUTE COUNT	0.03	X 10³ / µL	0.02 - 0.5
IMMATURE GRANULOCYTES(IG)	0.02	X 10³ / µL	0.0-0.3
TOTAL RBC	**5**	**X 10^6/µL**	**3.8-4.8**
NUCLEATED RED BLOOD CELLS	0.01	X 10³ / µL	<0.01
NUCLEATED RED BLOOD CELLS %	0.01	%	<0.01
HEMOGLOBIN	13.7	g/dL	12.0-15.0
HEMATOCRIT(PCV)	**46.1**	**%**	**36.0-46.0**
MEAN CORPUSCULAR VOLUME(MCV)	92.2	fL	83.0-101.0
MEAN CORPUSCULAR HEMOGLOBIN(MCH)	27.4	pq	27.0-32.0
MEAN CORP.HEMO.CONC(MCHC)	**29.7**	**g/dL**	**31.5-34.5**
RED CELL DISTRIBUTION WIDTH - SD(RDW-SD)	**47.8**	**fL**	**39.0-46.0**
RED CELL DISTRIBUTION WIDTH (RDW-CV)	14	%	11.6-14.0
PLATELET DISTRIBUTION WIDTH(PDW)	14.8	fL	9.6-15.2
MEAN PLATELET VOLUME(MPV)	11.8	fL	6.5-12
PLATELET COUNT	291	X 10³ / µL	150-410
PLATELET TO LARGE CELL RATIO(PLCR)	39.1	%	19.7-42.4
PLATELETCRIT(PCT)	0.34	%	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)

Dummy Report

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

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REPORT

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : BLOOD SUGAR (F)

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
FASTING BLOOD SUGAR(GLUCOSE)	**PHOTOMETRY**	**104**	**mg/dL**

Reference Range :-

As per ADA Guideline: Fasting Plasma Glucose (FPG)	
Normal	70 to 100 mg/dl
Prediabetes	100 mg/dl to 125 mg/dl
Diabetes	126 mg/dl or higher

Note :
The assay could be affected mildly and may result in anomalous values if serum samples have heterophilic antibodies, hemolyzed , icteric or lipemic. The concentration of Glucose in a given specimen may vary due to differences in assay methods, calibration and reagent specificity. For diagnostic purposes results should always be assessed in conjunction with patients medical history, clinical findings and other findings.

Please correlate with clinical conditions.
Method:- GOD-PAP METHOD

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 : FLUORIDE
Labcode :
Barcode :

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REPORT

NAME : XXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : URINARY MICROALBUMIN,UROGRAM

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	TECHNOLOGY	VALUE	UNITS
DIABETES SCREEN (URINE)			
URINARY MICROALBUMIN	PHOTOMETRY	< 5.5	µg/mL
Reference Range : Adults: Less than 25 µg/ml **Method :** Fully Automated Immuno Turbidometry			
CREATININE - URINE	PHOTOMETRY	45.69	mg/dL
Reference Range : Male: 39 - 259 mg/dl Female: 28 - 217 mg/dl **Method :** Creatinine Jaffe Method, Rate-Blanked and Compensated			
URI. ALBUMIN/CREATININE RATIO (UA/C)	CALCULATED	12	µg/mg of Creatinine
Reference Range : Adults : Less than 30 µg/mg of Creatinine **Method :** Derived from Albumin and Creatinine values			

Please correlate with clinical conditions.

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 : URINE
Labcode :
Barcode :

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REPORT

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXX
TEST ASKED : UROG

SAMPLE COLLECTED AT :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	OBSERVATION	UNITS	REFERENCE RANGE
Complete Urinogram			
Physical Examination			
SPECIFIC GRAVITY	1.01	-	1.003-1.030
PH	5.5	-	5 - 8
Chemical Examination			
URINARY GLUCOSE	ABSENT	mg/dL	Absent
URINARY BILIRUBIN	ABSENT	mg/dL	Absent
URINE KETONE	ABSENT	mg/dL	Absent
URINE BLOOD	ABSENT	-	Absent
URINARY PROTEIN	ABSENT	mg/dL	Absent
UROBILINOGEN	< 0.2	mg/dL	<=0.2
NITRITE	ABSENT	-	Absent
Microscopic Examination			
URINARY LEUCOCYTES (PUS CELLS)	ABSENT	cells/HPF	0-5

Method : Manual Dipstick Method, Microscopy

~~ 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 : URINE
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

CUSTOMER DETAILS

As declared in our data base

Name: XXXXXXXXXXXXXX **Age:** XXX **Sex:** XX **Customer Mobile No:** XXXXXXXXXX

Barcodes/Sample_Type	:	
Labcode	:	
Ref By	:	XXXXXXX
Sample_Type/Tests	:	EDTA:ELEMENTS 22 (TOXIC AND NUTRIENTS) , HBA , HEMOGRAM - 6 PART (DIFF) FLUORIDE:FBS URINE:UALB , URINOGRAM SERUM:AAROGYAM X WITH UTSH
Sample Collected At	:	
Sample Collected on (SCT)	:	Sample collection time
Report Released on (RRT)	:	Report release time

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Dummy Report

CONDITIONS OF REPORTING

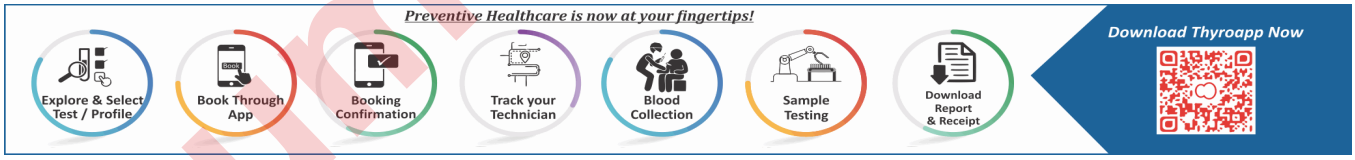
- The reported results are for information and interpretation of the referring doctor only.
- It is presumed that the tests performed on the specimen belong to the patient; named or identified.
- Results of tests may vary from laboratory to laboratory and also in some parameters from time to time for 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 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