Thyrocare

Tests you can trust

Name : XXXXXXXXXXXXXXXXX

Date : XXXXXXXX

Test Asked : Jaanch Hypertension Package

Report Status : Complete Report

Dummy Report



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



Accredited by

NABL From 2005#

ISO 9001: 2015 - From 2015

CAP From 2011~

Your reports are digitally verifiable

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

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

Temperature-Controlled Sample Logistics

Unique Barcode Tracking

Fully Automated Machines Inspected Daily

Abnormal Values Re-Checked Twice

Reports Verified By Expert MD Pathologists Stationed at Every Lab

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 : XXXXXXXXXXXX
Referred By : XXXXXXXXXXXX
Address : XXXXXXXXXXXX

Tests Done : JAANCH HYPERTENSION PACKAGE

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 HYPERTENSION PACKAGE	Ready
CORTISOL	Ready
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	Ready
Lipoprotein (a) [Lp(a)]	Ready
URINARY MICROALBUMIN	Ready
COMPLETE URINE ANALYSIS	Ready
HBA PROFILE	Ready
HEMOGRAM - 6 PART (DIFF)	Ready
LIVER FUNCTION TESTS	Ready
SERUM ELECTROLYTES	Ready
KIDPRO	Ready
LIPID PROFILE	Ready
TROPONIN I HEART ATTACK RISK	Ready
APOLIPROTEIN RATIO	Ready
Aldosterone / Plasma Direct Renin Ratio	Ready

Dummy Report

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 : XXXXXXXXXXXXX
Referred By : XXXXXXXXXXXXX
Address : XXXXXXXXXXXXX

Tests Done : JAANCH HYPERTENSION PACKAGE

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
COMPLETE URINE ANALYSIS			
SPECIFIC GRAVITY	**< 1.003**	-	1.003-1.030
LIPID			
LDL / HDL RATIO	**0.9**	Ratio	1.5-3.5
TC/ HDL CHOLESTEROL RATIO	**2.2**	Ratio	3 - 5
RENAL			
CREATININE - SERUM	**0.7**	mg/dL	0.72-1.18

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.

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
DIRECT RENIN	C.L.I.A	< 25.25	µIU/mL

Bio. Ref. Interval. :-

Upright position : 4.4 - 46.1 µIU/mL
Supine position : 2.8 - 39.9 µIU/mL

Clinical Significance:

The proteolytic enzyme renin is mainly synthesized in the kidneys as prorenin and is stored in granules as prorenin or renin. It plays a major role in the regulation of blood pressure, thirst and urine output. The estimation of renin activity is useful in the differential diagnosis of individuals with hypertension and primary aldosteronism.Renin can also be used to assess the adequacy of steroid substitution in patients with adrenal insufficiency.The levels of renin will be elevated in patients with hypertension due to renal artery stenosis, hemorrhage, heart failure, liver scaring, dehydration and kidney tumors.The decrease in renin levels might be due to high levels of aldosterone, high blood pressure and steroids treatment.

Kit Validation References: Direct Renin Assay and Plasma Renin Activity Assay Compared .Clinical Chemistry 2004 ; 50(11): 2159-2161

Please correlate with clinical conditions.

Method:- FULLY AUTOMATED SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY

Dummy Report

Tests Done : DIRECT RENIN,HBA PROFILE,HEMOGRAM

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002367/IT011

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
HbA1c	H.P.L.C	5.1	%

Bio. Ref. Interval. :

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

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

AVERAGE BLOOD GLUCOSE (ABG)	CALCULATED	100	mg/dL

Bio. Ref. Interval. :

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

Tests Done : DIRECT RENIN,HBA PROFILE,HEMOGRAM

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002367/IT011

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

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

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

Tests Done : DIRECT RENIN,HBA PROFILE,HEMOGRAM

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002367/IT011

Dummy Report

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
CORTISOL	E.C.L.I.A	10.8	µg/dL

Bio. Ref. Interval. :-

06.00 - 10.00 A.M.: 6.02 - 18.4 µg/dL
04.00 - 08.00 P.M.: 2.68 - 10.5 µg/dL

Clinical Significance:

Cortisol is the Primary Glucocorticoid Hormone synthesized and secreted by the Adrenal Cortex. Addison's Disease is caused by primary adrenal insufficiency of the Adrenal Cortex, While Secondary Adrenal insufficiency is caused by pituitary destruction or failure, resulting in loss of ACTH stimulation. Cushing's syndrome is caused by increased levels of Cortsol due to either primary (Adrenal Tumors and Nodular Adrenal Hyperplasia) or secondary Adrenal Hyperfunction (Pituitary Overproduction of ACTH or Ectopic production of ACTH by a Tumor). For diagnostic purpose, results should always be assessed in conjunction with the patients medical history, Clinical examination and other findings.

Specifications:

Precision: Intra Assay (%CV): 1.40 %, Inter Assay (%CV): 1.9 %; Sensitivity: 0.05 µg/dl

Kit Validation References :

Turpeinen U,hamalainen E.Determination of cortisol in serum,saliva and urine.Best practise & research Cliical Endocrinology & metabolisum 2013.27(6);795-801

Please correlate with clinical conditions.

Method:- FULLY AUTOMATED ELECTROCHEMILUMINESCENCE IMMUNOASSAY

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

Dummy Report

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
TROPONIN I HEART ATTACK RISK	C.M.I.A	1.88	pg/mL

Bio. Ref. Interval. :-

Cutoff values (Precision at 99th percentile) : Male : <= 26.2 || Female : <= 15.6

Clinical Significance:

The Cardiac Troponin I is cardiac specific and highly sensitive marker for myocardial damage. In acute myocardial damage the Troponin I values are raised 4-6 hrs after cardiac symptom onset and may remain elevated for a period of 7-12 days of cardiac injury. It is an independent risk marker that can predict near, mid and long term outcome in patients with Acute coronary syndrome. A single Troponin I result may not be sufficient to evaluate MI. Serial Blood draws are recommended to evaluate Acute coronary syndrome (ACS) patients.Increased levels of Cardiac troponin I can be seen in Myocarditis,heart contusion, cardiomyopathy,congestive heart failure,interventional therapy like cardiac surgery and drug induced cardiomyopathy. Any condition resulting in myocardial injury can potentially increase Troponin I levels.

Hence The results should always be used in conjunction with ECG changes, Clinical symptoms, other findings etc. to Diagnose MI. The various interfering factors / limitations of the Troponin I assay are - presence of heterophile antibodies, Patients on Human anti mouse monoclonal antibody (HAMA) therapy, Rheumatoid factor (RF), high total protein levels etc. The Coronary vascular disease risk stratification in Asymptomatic patients is as given in the below table, which can be suggested for preventive clinical management in conjunction with other clinical findings, investigations and clinical symptoms.

The following cut-off points may be used to aid in stratifying the risk of cardiovascular disease in asymptomatic individuals.

HIGH SENSITIVE TROPONIN-I LEVEL (pg/mL)		
MALE	**FEMALE**	**INTERPRETATION**
<6	<4	Low risk of future heart attack
≥6 to ≤12	≥4 to ≤10	Moderate risk of future heart attack
>12	>10	Elevated risk of future heart attack

Specifications: Precision at the 99th Percentiles

Females = 15.6 pg/mL -5.3% CV || Males = 34.2pg/mL - 3.5% CV

Kit validation reference :

1. Risk-Stratification of the Apparently Healthy Population for Future Cardiac Events With ARCHITECT High Sensitive Troponin-I(https://dam.abbott.com/de-de/documents/pdf/ADD- 00064393-hsTnI-Risk-Stratification-Sell-Sheet.pdf)

2. ARCHITECT STAT High Sensitive Troponin-I [package insert]. Lake Bluff, IL: Abbott Laboratories; 2018. G97079R01.

Please correlate with clinical conditions.

Method:- FULLY AUTOMATED CHEMI LUMINESCENT MICROPARTICLE IMMUNOASSAY

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

Dummy Report

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
APOLIPOPROTEIN - A1 (APO-A1)	IMMUNOTURBIDIMETRY	< 119	mg/dL

Bio. Ref. Interval. :
Male : 86 - 152
Female : 94 - 162

Method : FULLY AUTOMATED RATE IMMUNOTURBIDIMETRY – BECKMAN COULTER

APOLIPOPROTEIN - B (APO-B)	IMMUNOTURBIDIMETRY	< 101	mg/dL

Bio. Ref. Interval. :
Male : 56 - 145
Female : 53 - 138

Method : FULLY AUTOMATED RATE IMMUNOTURBIDIMETRY – BECKMAN COULTER

APO B / APO A1 RATIO (APO B/A1)	CALCULATED	0.8	Ratio

Bio. Ref. Interval. :

Male : 0.40 - 1.26
Female : 0.38 - 1.14

Clinical Significance :

- Apolipoprotein B is a more potent and independent predictor of Coronary artery disease (CAD) than LDL Cholesterol.
- Apolipoprotein A1 is one of the apoproteins of HDL and is inversely related to risk of CAD.
- The Apolipoprotein studies help in monitoring risk of restenosis in patients with myocardial infarction, Coronary bypass surgery etc.
- An increased ratio of Apo B to A1 beyond the defined normal range is indicative of CAD risk.
- All results have to be interpreted in Conjunction with clinical history and other findings.

Method : Derived from serum Apo A1 and Apo B values

Please correlate with clinical conditions.

Dummy Report

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
ALDOSTERONE	C.L.I.A	10	ng/dL

Bio. Ref. Interval. :-

Upright : 2.21 - 35.3 ng/dL
Supine : 1.17 - 23.6 ng/dL

Clinical Significance:

Aldosterone, a steroid hormone of adrenal cortex, has recently attracted much interest not only due to its primary role to promote unidirectional salt reabsorption in variety of epithelial cells and also due to pathophysiological effects in the reno cardiovascular system causing endothelial dysfunction, inflammation and remodeling. The elevated aldosterone level increases reabsorption of sodium (salt) and loss of potassium by the kidneys, often resulting in an electrolyte imbalance thus leading to high blood pressure, headache and muscle weakness, especially if potassium levels are very low. The decrease causes dehydration, low blood pressure, a low blood sodium level and a high potassium level. It also has a small effect on the metabolism of fats, carbohydrates and proteins.

Specifications: Precision: Intra Assay (%CV): 4.2 %, Inter Assay (%CV): 10.5%; Sensitivity: 1.45 ng/dL

Kit Validation References: Cartledge S, Lawson N.; Aldosterone and renin measurements,.Ann Clin Biochem 37: 262-278 (2000

Please correlate with clinical conditions.

Method:- FULLY AUTOMATED CHEMI LUMINESCENT IMMUNO ASSAY

Dummy Report

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
Lipoprotein (a) [Lp(a)]	IMMUNOTURBIDIMETRY	10	mg/dL

Bio. Ref. Interval. :-

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

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	IMMUNOTURBIDIMETRY	1.1	mg/L

Bio. Ref. Interval. :-

< 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

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

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

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TOTAL CHOLESTEROL	PHOTOMETRY	123	mg/dL	< 200
HDL CHOLESTEROL - DIRECT	PHOTOMETRY	56	mg/dL	40-60
LDL CHOLESTEROL - DIRECT	PHOTOMETRY	53.5	mg/dL	< 100
TRIGLYCERIDES	PHOTOMETRY	120	mg/dL	< 150
TC/ HDL CHOLESTEROL RATIO	**CALCULATED**	**2.2**	**Ratio**	**3 - 5**
TRIG / HDL RATIO	CALCULATED	2.12	Ratio	< 3.12
LDL / HDL RATIO	**CALCULATED**	**0.9**	**Ratio**	**1.5-3.5**
HDL / LDL RATIO	CALCULATED	1.05	Ratio	> 0.40
NON-HDL CHOLESTEROL	CALCULATED	66.2	mg/dL	< 160
VLDL CHOLESTEROL	CALCULATED	23.94	mg/dL	5 - 40

Please correlate with clinical conditions.

Method :

CHOL - Cholesterol Oxidase, Esterase, Peroxidase
HCHO - Direct Enzymatic Colorimetric
LDL - Direct Measure
TRIG - Enzymatic, End Point
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
HD/LD - Derived from HDL and LDL values.
NHDL - Derived from serum Cholesterol and HDL values
VLDL - Derived from serum Triglyceride 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

Tests Done : JAANCH HYPERTENSION PACKAGE

Report Remarks : Labcode:0506002368/IT011

Doctor 1 Sign

Doctor 2 Sign

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

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	0.1	mg/dL	0 - 0.20
BILIRUBIN (INDIRECT)	CALCULATED	0.35	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 - Diazonium salt DPD method
BILD - Diazonium salt DPD method
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 HYPERTENSION PACKAGE

Report Remarks : Labcode:0506002368/IT011

Doctor 1 Sign

Doctor 2 Sign

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
SODIUM	I.S.E - INDIRECT	137	mmol/L

Bio. Ref. Interval. :
Adults: 136-145 mmol/l

Method : ION SELECTIVE ELECTRODE - INDIRECT

POTASSIUM	I.S.E - INDIRECT	< 4.3	mmol/L

Bio. Ref. Interval. :
ADULTS: 3.5-5.1 MMOL/L

Clinical Significance :
An abnormal increase in potassium (hyperkalemia)can profoundly affect the nervous system and increase the chance of irregular heartbeats (arrhythmias), which ,when extreme ,can be fatal. 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 Potassium in a given specimen may vary due to differences in assay methods, calibration and reagent specificity.

Method : ION SELECTIVE ELECTRODE - INDIRECT

CHLORIDE	I.S.E - INDIRECT	101	mmol/L

Bio. Ref. Interval. :
ADULTS: 98-107 MMOL/L

Clinical Significance :
An increased level of blood chloride (called hyperchloremia) usually indicates dehydration, but can also occur with other problems that cause high blood sodium, such as Cushing syndrome or kidney disease. Hyperchloremia also occurs when too much base is lost from the body (producing metabolic acidosis) or when a person hyperventilates (causing respiratory alkalosis). A decreased level of blood chloride (called hypochloremia) occurs with any disorder that causes low blood sodium. Hypochloremia also occurs with congestive heart failure, prolonged vomiting or gastric suction, Addison disease, emphysema or other chronic lung diseases (causing respiratory acidosis), and with loss of acid from the body (called metabolic alkalosis).

Method : ION SELECTIVE ELECTRODE - INDIRECT

Please correlate with clinical conditions.

Dummy Report

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

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

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 HYPERTENSION PACKAGE

Report Remarks : Labcode:0506002368/IT011

Doctor 1 Sign **Doctor 2 Sign**

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
ALDOSTERONE/DIRECT RENIN RATIO	CALCULATED	0.4	Ratio

Bio. Ref. Interval. :-

ARR Value Interpretation
< 3.0 - Not suggestive of primary aldosteronism
3.0 – 3.7 - Borderline or Equivocal
> 3.7 - Elevated. may suggest primary aldosteronism when associated with elevated aldosterone

Clinical Significance :
1. The Aldosterone/Renin Ratio (ARR) is a screening parameter used in the evaluation of Primary Aldosteronism (PA) in appropriate clinical settings such as resistant hypertension, hypertension with hypokalemia, adrenal incidentaloma, or early-onset hypertension.
2. Important Limitations / Interpretation Notes
- ARR should not be interpreted in isolation.
Elevated ARR with low/normal aldosterone may not indicate primary aldosteronism.
- Many screening protocols consider ARR clinically significant only when accompanied by elevated aldosterone (commonly >=10-15 ng/dL, depending on institutional protocol)
Results may be affected by:
-Patient posture during sample collection
-Sodium intake / volume status
-Serum potassium status
-Antihypertensive / diuretic / steroid medications
-Renal dysfunction
-Pregnancy
- ARR cut-offs are assay/platform dependent and apply specifically to this laboratory's CLIA-based aldosterone and direct renin assays in the stated units.

Disclaimer
- Elevated ARR may be suggestive of primary aldosteronism in the appropriate clinical context, particularly when plasma aldosterone concentration is elevated. Clinical correlation and confirmatory testing are recommended where indicated.
References
1. Funder JW, Carey RM, Mantero F, et al. The Management of Primary Aldosteronism: Case Detection, Diagnosis, and Treatment: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2016 ,101(5):1889–1916.
2. Ma J, et al. Screening for primary aldosteronism using aldosterone-to-direct renin ratio in chemiluminescent immunoassay. Ann Transl Med. 2022.
3. ARUP Consult. Primary Aldosteronism Testing Algorithm – Aldosterone-Renin Ratio Interpretation.

Please correlate with clinical conditions.

Method:- DERIVED FROM ALDOSTERONE AND DIRECT RENIN VALUES

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

Dummy Report

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

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
<15 : Kidney Failure

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

Dummy Report

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506002368/IT011

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	: XXXXXXXXXXXX	Sample Collected on (SCT)	: XXXXXXXXXXXX
Referred By	: XXXXXXXXXXXX	Sample Received on (SRT)	: XXXXXXXXXXXX
Address	: XXXXXXXXXXXX	Report Released on (RRT)	: XXXXXXXXXXXX
		Sample Type | Barcode	: XXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
DIABETES SCREEN (URINE)			
URINARY MICROALBUMIN	PHOTOMETRY	< 12.46	µg/mL
Bio. Ref. Interval. : Adults: Less than 25 µg/ml			
Method : Fully Automated Immuno Turbidometry			
CREATININE - URINE	PHOTOMETRY	< 149	mg/dL
Bio. Ref. Interval. : 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	8.4	µg/mg of Creatinine
Bio. Ref. Interval. : Adults : Less than 30 µg/mg of Creatinine			
Method : Derived from Albumin and Creatinine values			

Please correlate with clinical conditions.

Dummy Report

Tests Done : JAANCH HYPERTENSION PACKAGE

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506122356/IT011

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

TEST NAME	METHODOLOGY	VALUE	UNITS	Bio. Ref. Interval.
Complete Urinogram				
Physical Examination				
VOLUME	Visual Determination	1	mL	-
COLOUR	Visual Determination	PALE YELLOW	-	Pale Yellow
APPEARANCE	Visual Determination	CLEAR	-	Clear
SPECIFIC GRAVITY	**pKa change**	**< 1.003**	**-**	**1.003-1.030**
PH	pH indicator	5	-	5-8
Chemical Examination				
URINARY PROTEIN	PEI	ABSENT	mg/dL	Absent
URINARY GLUCOSE	GOD-POD	ABSENT	mg/dL	Absent
URINE KETONE	Nitroprusside	ABSENT	mg/dL	Absent
URINARY BILIRUBIN	Diazo coupling	ABSENT	mg/dL	Absent
UROBILINOGEN	Diazo coupling	Normal	mg/dL	<=0.2
BILE SALT	Hays sulphur	ABSENT	-	Absent
BILE PIGMENT	Ehrlich reaction	ABSENT	-	Absent
URINE BLOOD	Peroxidase reaction	ABSENT	-	Absent
NITRITE	Diazo coupling	ABSENT	-	Absent
LEUCOCYTE ESTERASE	Esterase reaction	ABSENT	-	Absent
Microscopic Examination				
MUCUS	Microscopy	ABSENT	-	Absent
RED BLOOD CELLS	Microscopy	1	cells/HPF	0-2
URINARY LEUCOCYTES (PUS CELLS)	Microscopy	2.5	cells/HPF	0-5
EPITHELIAL CELLS	Microscopy	2.5	cells/HPF	0-5
CASTS	Microscopy	ABSENT	-	Absent
CRYSTALS	Microscopy	ABSENT	-	Absent
BACTERIA	Microscopy	ABSENT	-	Absent
YEAST	Microscopy	ABSENT	-	Absent
PARASITE	Microscopy	ABSENT	-	Absent

(Reference : *PEI - Protein error of indicator, *GOD-POD - Glucose oxidase-peroxidase**)**

~~ End of report ~~

Dummy Report

Tests Done : COMPLETE URINE ANALYSIS

Doctor 1 Sign **Doctor 2 Sign**

Report Remarks : Labcode:0506122356/IT011

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*

During Report