

LABORATORY REPORT

NAME	██████████	REFERRED BY	: █████	VISIT NO	: █████
AGE	██████			COLLECTED ON	: █████
GENDER	: █████	LAB MR#	: █████	RECEIVED ON	: █████
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Test Name	Result	Biological Ref. Interval	Unit
Obesity Risk Check			

HAEMATOLOGY

Complete Blood Counts (Whole Blood - EDTA)

(Automated Hematology Analyzer & Microscopy)

Hemoglobin	13.0	12.0 - 15.0	g/dL
RBC Count	4.6	3.8 - 4.8	10 ⁶ /μL
Hematocrit	39.2 L	40 - 50	%
MCV(Mean Corpuscular Volume)	86.0	83 - 101	fL
MCH(Mean Corpuscular Hemoglobin)	28.4	27 - 32	pg
MCHC(Mean Corpuscular Hemoglobin Concentration)	33.1	31.5 - 34.5	g/dL
RDW	15.5 H	11.6 - 14	%
Total Leukocyte Count	4.6	4.0 - 11.0	10 ³ /μl

Differential count % (VCSn Technology & light microscopy)

Neutrophils	52.7	40-80%	%
Lymphocytes	36.3	20-40%	%
Monocytes	7.4	2-10%	%
Eosinophils	2.2	1-6%	%
Basophils	1.4 H	0-1%	%

Differential Counts, Absolute(calculated)

Absolute Neutrophil Count	2.40	2.0-7.0	10 ³ /μl
Absolute Lymphocyte Count	1.66	1.0-3.0	10 ³ /μl
Absolute Monocyte Count	0.34	0.2 - 1.0	10 ³ /μl
Absolute Eosinophil Count (AEC)	0.10	0.02 - 0.5	10 ³ /μl
Absolute Basophil Count	0.06	0.02 - 0.1	10 ³ /μl
Platelet Count	244	150 - 410	10 ³ /μl
MPV	8.4	7.5 - 11.5	fL

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Obesity Risk Check

BIOCHEMISTRY

Glucose - Fasting (Fluoride Plasma - F)

Glucose - Fasting <i>Hexokinase</i>	91.0	Normal : 74-100 Pre-diabetic : 100-125 Diabetic: >=126	mg/dL
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HbA1c - Glycated Hemoglobin (Whole Blood - EDTA)

Glycated Hemoglobin, HbA1c <i>TINIA</i>	5.19	Non diabetic range: 4.8-5.6 Prediabetic range: 5.7-6.4% Diabetes range: >=6.5%	%
Estimated Average Glucose	102.2		mg/dL

Interpretation:

Note: HbA1c results may vary in situations of abnormal red cell turnover, such as pregnancy, recent blood loss or transfusion, or some anemias. In such cases only blood glucose criteria should be used to diagnose diabetes (ADA, 2014). Please correlate clinically.

Lipid profile (Serum)

Cholesterol Total - Serum <i>Enzymatic colorimetric</i>	171.5	<200 No risk 200-239 Moderate risk >240 High risk	mg/dL
Triglycerides <i>Enzymatic colorimetry</i>	73.7	Normal: <150 Borderline-high: 150-199 High risk 200-499 Very high risk >500	mg/dL
Cholesterol - HDL (Direct) <i>Enzymatic colorimetric</i>	40.0	<40 High Risk ; >60 No Risk	mg/dL
LDL Chol, Calculated	116.72 H	<100	mg/dL
VLDL (Very Low Density Lipoprotein) <i>Calculation</i>	14.7	<30	mg/dL
Cho/HDL Ratio <i>Enzymatic colorimetric & Calculation</i>	4.28 H	Normal:<4.0 Low risk:4.0-6.0 Hisk risk:>6.0	
LDL/HDL Ratio	2.92		

Kindly Correlate Clinically



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Obesity Risk Check

CLINICAL PATHOLOGY

Urine Examination - Routine & Microscopy (CUE) (Urine)

PHYSICAL EXAMINATION:

Volume	30.00		mL
Colour	PALE YELLOW	Pale	
Appearance	Clear	Clear	

CHEMICAL EXAMINATION:

pH	5.00	4.8 - 7.4	
<i>Dip stick</i>			
Specific Gravity	1.020	1.010 - 1.022	
<i>Dip Stick(Bromothymol blue)</i>			
Protein	NEGATIVE	Negative	
<i>Dip Stick/ Sulfosalicylic acid</i>			
Glucose	NEGATIVE	Negative	
<i>Dip Stick /Benedicts test</i>			
Ketones	NEGATIVE	Negative	
<i>Dip stick</i>			
Urobilinogen	NORMAL	Normal	
<i>Dip Stick / Ehrlich reaction</i>			
Leucocyte Esterase	NEGATIVE		
Nitrite	NEGATIVE	Negative	
<i>Dip Stick / (Griess test)</i>			
Bilirubin	NEGATIVE	Negative	
<i>Dipstick/diazo</i>			
Blood	NEGATIVE	Negative	
<i>Dip Stick (Peroxidase)</i>			

Microscopic Examination

Pus Cells	3-5	0 - 5	/HPF
Epithelial Cells	2-3	< 5	/HPF
RBCs	NIL	0 - 2	/HPF
Casts	Absent	Absent	/LPF
Crystals	Absent	Absent	/HPF

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Obesity Risk Check

BIOCHEMISTRY

Uric acid (Serum)

Uric acid <i>Uricase</i>	4.7	2.4-5.7	mg/dL
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Blood Urea Nitrogen, BUN - Serum (Serum)

Blood Urea Nitrogen (BUN) <i>Calculation</i>	8.95	7-19	mg/dL
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Creatinine (Serum)

Creatinine <i>Modified Jaffe Kinetic</i>	0.79	< 1.20	mg/dL
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Protein Total, Serum (Serum)

Protein Total, Serum <i>Biuret Method</i>	6.9	6.4-8.3	g/dL
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Urea (Serum)

Urea <i>Kinetic, Urease</i>	19.2	16 - 38	mg/dL
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Calcium - Serum (Serum)

Calcium - Serum <i>NM-BAPTA</i>	9.35	8.6 - 10.0	mg/dL
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Electrolytes (Na, K, Cl) - Serum (Serum)

Sodium - Serum <i>ISE Indirect</i>	140.2	136 - 145	mmol/L
Potassium <i>ISE Indirect</i>	4.43	3.5-5.1	mmol/L
Chloride - Serum <i>ISE Indirect</i>	106.0	98-107	mmol/L

T3 - Total (Tri Iodothyronine) (Serum)

T3 - Total (Tri Iodothyronine) <i>ECLIA</i>	109.1	80.00 - 200.00	ng/dL
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T4 - Total (Thyroxine - Total) (Serum)

T4 - Total (Thyroxine - Total) <i>ECLIA</i>	10.47	5.1-14.1	µg/dL
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Obesity Risk Check
Interpretation:

Note :

- Total T3 & T4 levels measure the hormone which is in the bound form and is not available to most tissues.
- Severe systemic illness affects the thyroid binding proteins and can falsely alter Total T 4 levels in the absence of a primary thyroid disease. Hence Free T3 & T4 levels are recommended for accurate assessment of thyroid dysfunction.

TSH, Thyroid Stimulating Hormone (Serum)

TSH, Thyroid Stimulating Hormone ECLIA	5.180 H	Women (Non pregnant):0.27-4.2 µIU/mL Pregnant women 1st trimester:0.1-2.5 2nd trimester: 0.2-3.0 3rd trimester: 0.3-3.0
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Interpretation:

- The following potential sources of variation should be considered while interpreting thyroid hormone results:
- Circadian variation in TSH secretion: peak levels are seen between 2-4 am. Minimum levels seen between 6-10 am. This variation may be as much as 50% thus, influence of sampling time needs to be considered for clinical interpretation.
 - Total T3 and T4 levels are seen to have physiological rise during pregnancy and in patients on steroid treatment
 - Circulating forms of T3 and T4 are mostly reversibly bound with Thyroxine binding globulins (TBG), and to a lesser extent with albumin and Thyroid binding Pre-Albumin. Thus the conditions in which TBG and protein levels alter such as chronic liver disorders, pregnancy, excess of estrogens, androgens, anabolic steroids and glucocorticoids may cause misleading total T3, total T4 and TSH interpretations.
 - T4 may be normal in the presence of hyperthyroidism under the following conditions : T3 thyrotoxicosis, Hypoproteinemia related reduced binding, in presence of drugs (eg Phenytoin, Salicylates etc)
 - Neonates and infants have higher levels of T4 due to increased concentration of TBG
 - TSH levels may be normal in central hypothyroidism, recent rapid correction of hypothyroidism or hyperthyroidism, pregnancy, phenytoin therapy etc.
 - TSH values of <0.03 uIU/mL must be clinically correlated to evaluate the presence of a rare TSH variant in certain individuals which is undetected by conventional methods.
 - Presence of Autoimmune disorders may lead to spurious results of thyroid hormones
 - Various drugs can lead to interference in test results
- It is recommended to evaluate unbound fractions, that is free T3 (fT3) and free T4 (fT4) for clinic-pathologic correlation, as these are the metabolically active forms.

Vitamin D, 25-Hydroxy (Serum)

Vitamin D, 25-Hydroxy ECLIA	11.8 L	Deficient: <=20 Insufficiency: 20-29 Desirable: >=30-100 Toxicity: >100	ng/ml
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Kindly Correlate Clinically

Interpretation:

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Obesity Risk Check

Vitamin D is a fat soluble vitamin produced in the skin by exposure to sun light. Deficiency in children causes rickets and in adults leads to osteomalacia

Decreased levels:

- >Impaired cutaneous production (lack of sunlight exposure)
- >Dietary absence
- >Malabsorption
- >Increased metabolism due to drugs like barbiturates, phenytoin.
- >Liver disease
- >Renal failure
- >VIT D receptor mutation

Increased levels:

- >Vitamin D intoxication due to increased vit D supplements intake

Vitamin B12 (Serum)

Vitamin B12	288.2	191-771	pg/mL
<i>ECLIA</i>			

Interpretation:

Vitamin B12 also referred to as cobalamin is a water soluble vitamin. The uptake in the gastro intestinal track depends on intrinsic factor, which is synthesised by gastric parietal cells

Deficiency state:

- >Lack of intrinsic factor due to autoimmune atrophic gastritis
- >Mal-absorption due to gastrostomy
- >Inflammatory bowel disease
- >Dietary deficiency (strict vegans)
- >Vit B12 deficiency results in megaloblastic anaemia, peripheral neuropathy, dementia and depression

Increased levels:

- >VIT B12 supplement intake
- >Polycythaemia Vera.

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Obesity Risk Check			
Cortisol AM (Serum)			
Cortisol AM ECLIA	14.70	Morning hours (6-10 a.m.): 6.2- 19.4 Evening hours (4-8 p.m.): 2.3-11.9	µg/dL

Interpretation:

Cortisol is a steroid hormone secreted by adrenal cortex

Elevated cortisol levels seen in:

1. Cushing syndrome due to primary adrenal disease (adenoma, carcinoma or nodular hyperplasia), secondary to excess of ACTH pituitary adenoma.
2. Stress

Decreased cortisol levels seen in:

1. Addison disease-primary adrenal insufficiency
2. Secondary adrenal insufficiency
3. Pituitary insufficiency

██████████
 ██████████

██████████
 ██████████

Consultant- Biochemist

Consultant Pathologist

Disclaimer:

1. All results released pertain to the specimen as received by the lab for testing and under the assumption that the patient indicated or identified on the bill/test requisition form is the owner of the specimen.
2. Clinical details and consent forms, especially in Genetic testing, histopathology, as well as wherever applicable, are mandatory to be accompanied with the test requisition form. The non-availability of such information may lead to delay in reporting as well as misinterpretation of test results. The lab will not be responsible for any such delays or misinterpretations thereof.
3. Test results are dependent on the quality of the sample received by the lab. In case the samples are preprocessed elsewhere (e.g., paraffin blocks), results may be compromised.
4. Tests are performed as per the schedule given in the test listing and in any unforeseen circumstances, report delivery may

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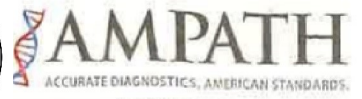
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MC-2751



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Obesity Risk Check

be affected.

5. Test results may show inter-laboratory as well as intra-laboratory variations as per the acceptable norms.

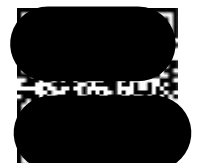
6. Genetic reports as well as reports of other tests should be correlated with clinical details and other available test reports by a qualified medical practitioner. Genetic counselling is advised in genetic test reports by a qualified genetic counsellor, medical practitioner or both.

7. Samples will be discarded post processing after a specified period as per the laboratory's retention policy. Kindly get in touch with the lab for more information.

8. If accidental damage, loss, or destruction of the specimen is not attributable to any direct or negligent act or omission on the part of Ampath Labs or its employees, Ampath shall in no event be liable. Ampath lab's liability for a lack of services, or other mistakes and omissions, shall be restricted to the amount of the patient's payment for the pertinent laboratory services.

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AmPath upholds rigorous standards for operational and clinical performance based on US hospital benchmarks. Test results have been furnished in adherence with these standards and under terms and conditions found on the reverse. For details, please email AmPath at customersupport@ampath.com or call: 040 6719 9977.