



LABORATORY REPORT

NAME :	██████████	REFERRED BY :	...	VISIT NO :	██████████
AGE :	██████████	██████████	██████████	COLLECTED ON :	██████████
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Test Name	Result	Biological Ref. Interval	Unit
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Advance Health Check

HAEMATOLOGY

Complete Blood Counts (Whole Blood - EDTA)

(Automated Hematology Analyzer & Microscopy)

Hemoglobin <i>photometric method</i>	15.3	13.0 - 17.0	g/dL
RBC Count <i>coulter principle</i>	5.1	4.5 - 5.5	10 ⁶ /μL
Hematocrit	46.7	40 - 50	%
MCV(Mean Corpuscular Volume) <i>Derived from RBC Histogram</i>	91.5	83 - 101	fL
MCH(Mean Corpuscular Hemoglobin) <i>Calculated</i>	30.0	27 - 32	pg
MCHC(Mean Corpuscular Hemoglobin Concentration) <i>Calculated</i>	32.8	31.5 - 34.5	g/dL
RDW <i>Derived from RBC Histogram</i>	13.8	11.6 - 14	%
Total Leukocyte Count <i>coulter principle</i>	8.7	4.0 - 10.0	10 ³ /μl

Differential count % (VCSn Technology & light microscopy)

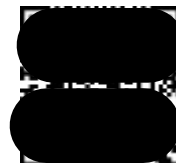
Neutrophils	66.0	40-80	%
Lymphocytes	24.0	20-40	%
Monocytes	6.0	2-10	%
Eosinophils	4.0	1-6	%
Basophils	0.0	0-1	%

Differential Counts, Absolute(calculated)

Absolute Neutrophil Count <i>VCSn/Calculated</i>	5.74	2.0-7.0	10 ³ /μl
Absolute Lymphocyte Count <i>VCSn/Calculated</i>	2.09	1.0-3.0	10 ³ /μl
Absolute Monocyte Count	0.52	0.2 - 1.0	10 ³ /μl
Absolute Eosinophil Count (AEC) <i>VCSn/Calculated</i>	0.35	0.02-0.5	10 ³ /μl
Absolute Basophil Count	0.10	0.02 - 0.1	10 ³ /μl
Platelet Count <i>coulter principle</i>	259	150 - 410	10 ³ /μl
MPV	12.3 H	7.5 - 11.5	fL

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Advance Health Check

BIOCHEMISTRY

Glucose - Fasting (Fluoride Plasma - F)

Glucose - Fasting <i>Hexokinase</i>	127.0 H	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>	6.30 H	Non diabetic range: 4.8-5.6% Prediabetic range: 5.7-6.4% Diabetes range: >=6.5%	%
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Estimated Average Glucose	134.1		mg/dL
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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>	108.0	No risk: <200 Moderate risk: 200-239 High risk: >240	mg/dL
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Triglycerides <i>Enzymatic colorimetry</i>	122.4	Normal: <150 Borderline-high: 150-199 High risk 200-499 Very high risk >500	mg/dL
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Cholesterol - HDL (Direct) <i>Enzymatic colorimetric</i>	38.0 L	High Risk: <40 No Risk: >60	mg/dL
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LDL Chol, Calculated	45.52	<100	mg/dL
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VLDL (Very Low Density Lipoprotein) <i>Calculation</i>	24.5	<30	mg/dL
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Cho/HDL Ratio <i>Enzymatic colorimetric & Calculation</i>	2.84	Normal:<4.0 Low risk:4.0-6.0 High risk:>6.0	
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LDL/HDL Ratio	1.20	Desirable/Low Risk: 0.5 - 3.0 Borderline/Moderate: 3.1 - 6.0 High Risk: >6.0	
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LFT(Bilirubin Total, Bilirubin Conjugated, (Serum)

Bilirubin Total <i>Diazo method</i>	0.56	<1.1	mg/dL
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Bilirubin Conjugated ██████████	0.26 H	<=0.2	mg/dL
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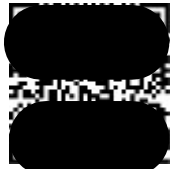
Test Name	Result	Biological Ref. Interval	Unit
Advance Health Check			
<i>Diazo method</i>			
Bilirubin Unconjugated, Indirect	0.30	<1.0	mg/dL
<i>Calculation</i>			
Aspartate Aminotransferase (AST/SGOT)	23	< 40	U/L
<i>IFCC kinetic</i>			
Alanine aminotransferase - (ALT / SGPT)	25	10 - 50	U/L
<i>Kinetic IFCC</i>			
Alkaline Phosphatase - ALP	78.0	<129	U/L
<i>IFCC kinetic</i>			

Interpretation:

1. In an asymptomatic patient, Non alcoholic fatty liver disease (NAFLD) is the most common cause of increased AST, ALT levels. NAFLD is considered as hepatic manifestation of metabolic syndrome.
2. In most type of liver disease, ALT activity is higher than that of AST; exception may be seen in Alcoholic Hepatitis, Hepatic Cirrhosis, and Liver neoplasia. In a patient with Chronic liver disease, AST:ALT ratio>1 is highly suggestive of advanced liver fibrosis.
3. In known cases of Chronic Liver disease due to Viral Hepatitis B & C, Alcoholic liver disease or NAFLD, Enhanced liver fibrosis (ELF) test may be used to evaluate liver fibrosis.
4. In a patient with Chronic Liver disease, AFP and Des-gamma carboxyprothrombin (DCP)/PIVKA II can be used to assess risk for development of Hepatocellular Carcinoma.

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Advance Health Check

CLINICAL PATHOLOGY

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

PHYSICAL EXAMINATION:

Volume	15.00		mL
Colour	Pale Yellow	Pale	
Appearance	Clear	Clear	

CHEMICAL EXAMINATION:

pH	6.50	4.8 - 7.4	
<i>Dip stick</i>			
Specific Gravity	1.010	1.010 - 1.022	
<i>Dip Stick (Bromothymol blue)</i>			
Protein	Absent	Negative	
<i>Dip Stick / Sulfosalicylic acid</i>			
Glucose	Positive (1+)	Negative	
<i>Dip Stick / Benedict's test</i>			
Ketones	Absent	Negative	
<i>Dip stick / Sodium nitroprusside reaction</i>			
Urobilinogen	Normal	Normal	
<i>Dip Stick / Ehrlich reaction</i>			
Leucocyte Esterase	Negative	Negative	
<i>Dip Stick</i>			
Nitrite	Negative	Negative	
<i>Dip Stick / (Griess test)</i>			
Bilirubin	Negative	Negative	
<i>Dipstick/diazo</i>			
Blood	Not Detected	Negative	
<i>Dip Stick (Peroxidase)</i>			

Microscopic Examination

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

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BIOCHEMISTRY			
Uric acid (Serum)			
Uric acid <i>Uricase</i>	5.9	3.4-7	mg/dL
Blood Urea Nitrogen, BUN - Serum (Serum)			
Blood Urea Nitrogen (BUN) <i>Calculation</i>	11.82	8.8-20.5	mg/dL
Protein Total, Serum (Serum)			
Protein Total, Serum <i>Biuret Method</i>	6.9	6.4-8.3	g/dL
Urea (Serum)			
Urea <i>Kinetic, Urease</i>	25.3	19 - 49	mg/dL
Creatinine (Serum)			
Creatinine <i>Modified Jaffe Kinetic</i>	0.84	0.70 - 1.20	mg/dL
Calcium - Serum (Serum)			
Calcium - Serum <i>NM-BAPTA</i>	10.00	8.6 - 10.0	mg/dL
Electrolytes (Na, K, Cl) - Serum (Serum)			
Sodium - Serum <i>ISE Indirect</i>	139.0	136 - 145	mmol/L
Potassium <i>ISE Indirect</i>	4.30	3.5-5.1	mmol/L
Chloride - Serum <i>ISE Indirect</i>	99.7	98-107	mmol/L
T3 - Total (Tri Iodothyronine) (Serum)			
T3 - Total (Tri Iodothyronine) <i>ECLIA</i>	142.5	80.00 - 200.00	ng/dL
T4 - Total (Thyroxine - Total) (Serum)			
T4 - Total (Thyroxine - Total) <i>ECLIA</i>	6.94	5.1-14.1	µg/dL

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Advance Health 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	4.900 H	0.27 - 4.21	µIU/mL
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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.

Serum Iron (Serum)

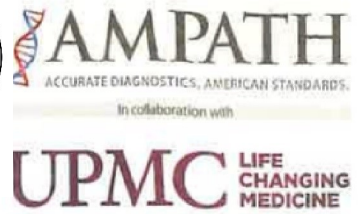
Iron FerroZine Colorimetric Assay	84.9	59-158	µg/dL
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Interpretation:

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron, leads to microcytic hypochromic anemia. The toxic effects of iron are deposition of iron in various organs of the body and hemochromatosis.



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Advance Health Check

 Consultant- Biochemist	 MBBS/MD (Pathology)
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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 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.