



LABORATORY REPORT

NAME : MR. PR1018 REFERRED BY : SELF VISIT NO : VAZ426000010
AGE : 40Y 0M 0D ZERO TARIFF CLIENT CODE COLLECTED ON : 20-04-2026 16:25
GENDER : Male LAB MR# : AAZ400000009 RECEIVED ON : 20-04-2026 17:50
OP / IP / DG # : APPROVED ON : 20-04-2026 18:32
REPORT STATUS : Final Report



Test Name	Result	Biological Ref. Interval	Unit
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Am-Fit Senior Citizen - Male

HAEMATOLOGY

Complete Blood Counts (Whole Blood - EDTA)

(Automated Hematology Analyzer & Microscopy)

Hemoglobin <i>photometric method</i>	13.7	13.0 - 17.0	g/dL
RBC Count <i>coulter principle</i>	4.7	4.5 - 5.5	10 ⁶ /μL
Hematocrit <i>Calculated</i>	40.0	40 - 50	%
MCV(Mean Corpuscular Volume) <i>Derived from RBC Histogram</i>	84.8	83 - 101	fL
MCH(Mean Corpuscular Hemoglobin) <i>Calculated</i>	29.2	27 - 32	pg
MCHC(Mean Corpuscular Hemoglobin Concentration) <i>Calculated</i>	34.5	31.5 - 34.5	g/dL
RDW <i>Derived from RBC Histogram</i>	12.9	11.6 - 14	%
Total Leukocyte Count <i>coulter principle</i>	9.9	4.0 - 10.0	10 ³ /μl

Differential count % (VCSn & Microscopy)

Neutrophils	65.0	40-80	%
Lymphocytes	30.0	20-40	%
Monocytes	4.0	2-10	%
Eosinophils	1.0	1-6	%
Basophils	0.0	0-1	%

Differential Counts, Absolute(calculated)

Absolute Neutrophil Count	6.44	2.0-7.0	10 ³ /μl
Absolute Lymphocyte Count	2.97	1.0-3.0	10 ³ /μl
Absolute Monocyte Count	0.40	0.2 - 1.0	10 ³ /μl
Absolute Eosinophil Count (AEC)	0.10	0.02-0.5	10 ³ /μl
Platelet Count <i>coulter principle</i>	186	150 - 410	10 ³ /μl
MPV <i>Derived from platelet histogram</i>	8.5	7.5 - 11.5	fL





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Am-Fit Senior Citizen - Male

BIOCHEMISTRY

Lipid profile (Serum)

Cholesterol Total - Serum <i>Enzymatic colorimetric</i>	181.0	No risk: <200 Moderate risk: 200-239 High risk: >240	mg/dL
Triglycerides <i>Enzymatic colorimetry</i>	142.0	Normal: <150 Borderline-high: 150-199 High risk 200-499 Very high risk >500	mg/dL
Cholesterol - HDL (Direct) <i>Enzymatic colorimetric</i>	63.0	High Risk: <40 No Risk: >60	mg/dL
LDL Chol, Calculated	89.60	Optimal:<100 Near optimal:100 - 129 Borderline high:130-159 High risk:160 - 189	mg/dL
VLDL (Very Low Density Lipoprotein) <i>Calculation</i>	28.4	<30	mg/dL
Cho/HDL Ratio <i>Enzymatic colorimetric & Calculation</i>	2.87	Normal:<4.0 Low risk:4.0-6.0 High risk:>6.0	
LDL/HDL Ratio	1.42	Desirable/Low Risk: 0.5 - 3.0 Borderline/Moderate: 3.1 - 6.0 High Risk: >6.0	

LFT(Bilirubin Total, Bilirubin Conjugated, (Serum)

Bilirubin Total <i>Diazo method</i>	0.60	<1.1	mg/dL
Bilirubin Conjugated <i>Diazo method</i>	0.2	<=0.2	mg/dL
Bilirubin Unconjugated, Indirect <i>Calculation</i>	0.40	<1.0	mg/dL
Aspartate Aminotransferase (AST/SGOT) <i>IFCC kinetic</i>	34	< 40	U/L
Alanine aminotransferase - (ALT / SGPT) <i>Kinetic IFCC</i>	31	< 41.0	U/L
Alkaline Phosphatase - ALP <i>IFCC kinetic</i>	112.0	<129	U/L

Interpretation:

1. In an asymptomatic patient, Non alcoholic fatty liver disease (NAFLD) is the most common cause of increased AST,

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Page 2 of 10



Sin No: 20385028,20385029,20385030,20385031



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Am-Fit Senior Citizen - Male			
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.			
Blood Urea Nitrogen, BUN - Serum (Serum)			
Blood Urea Nitrogen (BUN) <i>Calculation</i>	10.28	8.8-20.5	mg/dL
Creatinine (Serum)			
Creatinine <i>Modified Jaffe Kinetic</i>	1.0	0.70 - 1.20	mg/dL
Urea (Serum)			
Urea <i>Kinetic, Urease</i>	22.0	19.0 - 49.0	mg/dL
Uric acid (Serum)			
Uric acid <i>Uricase</i>	5.6	3.6 - 8.2	mg/dL





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Am-Fit Senior Citizen - Male			

CLINICAL PATHOLOGY

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

PHYSICAL EXAMINATION:

Volume	25.00		mL
Colour	Pale Yellow	Pale	
Appearance	Clear	Clear	

CHEMICAL EXAMINATION:

pH	6.50	4.8 - 7.4	
Dip stick			
Specific Gravity	1.020	1.010 - 1.022	
Dip Stick(Bromothymol blue)			
Protein	Negative	Negative	
Dip Stick/ Sulfosalicylic acid			
Glucose	Negative	Negative	
Dip Stick /Benedicts test			
Ketones	Absent	Negative	
Dip stick/Sodium nitroprusside reaction			
Urobilinogen	Normal	Normal	
Dip Stick / Ehrlich reaction			
Leucocyte Esterase	Negative	Negative	
Dip Stick			
Nitrite	Negative	Negative	
Dip Stick / (Griess test)			
Bilirubin	Negative	Negative	
Dipstick/diazo			
Blood	Not Detected	Negative	
Dip Stick (Peroxidase)			

Microscopic Examination

Pus Cells	1 - 2	0 - 5	/HPF
Epithelial Cells	1 - 2	< 5	/HPF
RBCs	Absent	0 - 5	/HPF
Casts	Absent	Absent	/LPF
Crystals	Absent	Absent	/HPF





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Am-Fit Senior Citizen - Male

BIOCHEMISTRY

Calcium - Serum (Serum)

Calcium - Serum NM-BAPTA	9.10	8.6 - 10.0	mg/dL
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Vitamin B12 (Serum)

Vitamin B12 ECLIA	491.00	197-771	pg/mL
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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. Vit B12 deficiency results in megaloblastic anaemia, peripheral neuropathy, dementia and depression

Deficiency state can be due to - Lack of intrinsic factor due to autoimmune atrophic gastritis, mal-absorption due to gastrectomy, Inflammatory bowel disease, dietary deficiency (strict vegans).

Increased levels can be due to - VIT B12 supplement intake, polycythaemia Vera.

Vitamin D, 25-Hydroxy (Serum)

Vitamin D, 25-Hydroxy ECLIA	62.0	Deficient: <=20 Insufficiency: 20-29 Desirable: >=30-100 Toxicity: >100	ng/ml
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Interpretation:

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 can be due to- 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 can be due to - increased vit D supplements intake

HbA1c - Glycated Hemoglobin (Whole Blood - EDTA)

Glycated Hemoglobin, HbA1c HPLC	5.00	Non diabetic range: 4.8-5.6 Prediabetic range: 5.7-6.4 Diabetes range: >=6.5	%
Estimated Average Glucose	96.8		mg/dL

Interpretation:

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, 2024). Please correlate clinically.

Glucose - Fasting (Fluoride Plasma - F)

Glucose - Fasting	79.0	Normal : 74-100	mg/dL
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Generated On 24-Apr-2026 19:03:56

This is an electronically authenticated laboratory report.

Page 5 of 10



Sin No: 20385028,20385029,20385030,20385031



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Test Name	Result	Biological Ref. Interval	Unit
Am-Fit Senior Citizen - Male <i>Hexokinase</i>		Pre-diabetic : 100-125 Diabetic: >=126	
T3 - Total (Tri Iodothyronine) (Serum)			
T3 - Total (Tri Iodothyronine) ECLIA	165.0	80.00 - 200.00	ng/dL
T4 - Total (Thyroxine - Total) (Serum)			
T4 - Total (Thyroxine - Total) ECLIA	12.00	5.1-14.1	µg/dL

Interpretation:

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	2.850	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:

1. 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.
2. Total T3 and T4 levels are seen to have physiological rise during pregnancy and in patients on steroid treatment
3. 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.
4. 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)
5. Neonates and infants have higher levels of T4 due to increased concentration of TBG
6. TSH levels may be normal in central hypothyroidism, recent rapid correction of hypothyroidism or hyperthyroidism, pregnancy, phenytoin therapy etc.
7. 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.
8. Presence of Autoimmune disorders may lead to spurious results of thyroid hormones
9. 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.

Iron Binding Capacity - Total (TIBC) (Serum)

Iron FerroZine Colorimetric Assay	125.0	59-158	µg/dL
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Generated On 24-Apr-2026 19:03:56

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Page 6 of 10

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Unsaturated Iron Binding Capacity (UIBC) <i>Direct determination with FerroZine</i>	295.0	125 - 345	µg/dL
Iron Binding Capacity - Total (TIBC) <i>Calculation</i>	420.0	228-428	µg/dL
Transferrin Saturation Index (TSI) <i>Calculation</i>	29.8	16-45	

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.

Total iron-binding capacity (TIBC) is an essential test used for the diagnosis of iron deficiency anemias and other disorders of iron metabolism. Iron binding capacity is the capacity of transferrin to bind with iron. Iron binding capacity is of two types, TIBC and unsaturated iron-binding capacity (UIBC). TIBC is the total of serum iron and UIBC. When iron stores are depleted, the transferrin levels increase in the blood. As only one-third of transferrin is saturated with iron, so the transferrin present in serum has an extra binding capacity. This is unsaturated iron-binding capacity.

Increases in iron-binding capacity are observed with the following:

- Iron deficiency states
- Acute liver damage
- Acute and chronic blood loss
- Late pregnancy
- Progesterone birth control pills

Decreases in iron-binding capacity are associated with the following:

- Hemochromatosis
- Hemosiderosis
- Thalassemia
- Hyperthyroidism
- Nephrotic syndrome

Anemia of chronic diseases **Transferrin Saturation** occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.





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Am-Fit Senior Citizen - Male			

SEROLOGY AND IMMUNOLOGY

Hepatitis B Surface antigen (HBsAg) - Spot Test (Serum)

Hepatitis B Surface antigen (HBsAg) - Spot Test <i>Immunochromatography</i>	Negative	Negative
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Interpretation:

Test Observations:

HBsAg is the first marker to appear after Hepatitis B infection and may be observed 2 or 3 weeks before the clinical and biological symptoms of the disease appear. Its period of presence may be very short (a few days) or very long (several years). HBs Ag persisting beyond 6 months in the serum denotes "chronic hepatitis". Because of the existence of numerous asymptomatic chronic carriers, hepatitis B represents an important transfusion hazard and the prevention of the transmission is based upon the detection of the HBs Ag at the time of each blood donation. This is a screening test and all positive samples must be confirmed by confirmatory tests like Neutralization assay or PCR. False positive results can be obtained due to the presence of other antigens or elevated levels of Rheumatoid factor (RF), although this is seen in less than 1% of the samples tested.





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BIOCHEMISTRY

Ferritin (Serum)

Ferritin 135.00 30-400 ng/mL
ECLIA

Interpretation:

Ferritin is iron storage protein. Determination of ferritin is necessary in iron deficiency anemia, monitoring iron therapy and in differential diagnosis of anemia

Elevation levels seen in

- Hemochromatosis
- Porphyria
- Rheumatoid arthrosis
- Leukaemia
- Hodgkin's lymphoma
- Liver disease
- Multiple blood transfusion
- Acute phase reactant
- Increased in all inflammatory condition

Decreased level

- Iron deficiency anemia

PSA Total (Prostatic Specific Antigen, Total) (Serum)

PSA Total 0.80 <1.4 ng/mL
ECLIA

Interpretation:

PSA is a protein produced by prostate gland in males. PSA test is used primarily to screen for prostate cancer. PSA aids in early detection of prostate cancer follow up and management of prostate cancer patient during treatment & after surgery. Elevated levels are seen in benign prostatic hyperplasia, prostatitis, genitourinary infection

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Disclaimer:

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Page 9 of 10

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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.

