AMPATH
Central Reference Labor
Door No. 1-100/1/CCH N
Serilingampally
Hyderabad

MC-2751

AMPATH
ACCURATE DIAGNOSTICS, AMERICAN STANDARDS.

## LABORATORY REPORT

| | | | | | |
|---|---|---|---|---|---|
| **NAME** | **: MS. PR1019** | REFERRED BY | : SELF | VISIT NO | : VAZ426000019 |
| AGE | : 40Y 0M 0D | ZERO TARIFF CLIENT CODE | | COLLECTED ON | : 20-04-2026 16:40 |
| GENDER | : Female | **LAB MR#** | **: AAZ400000018** | RECEIVED ON | : 20-04-2026 17:54 |
| OP / IP / DG # | : | | | APPROVED ON | : 20-04-2026 18:03 |
| | | | | REPORT STATUS | : Final Report |

| Test Name | Result | Biological Ref. Interval | Unit |
|---|---|---|---|
| **Am-Fit Senior Citizen - Female** | | | |
| **HAEMATOLOGY** | | | |
| **Complete Blood Counts** *(Whole Blood - EDTA)* | | | |
| **(Automated Hematology Analyzer & Microscopy)** | | | |
| Hemoglobin<br>*photometric method* | 13.8 | 12.0 - 15.0 | g/dL |
| RBC Count<br>*coulter principle* | 4.6 | 3.8 - 4.8 | 10^6/µL |
| Hematocrit<br>*Calculated* | 40.6 | 36 - 46 | % |
| MCV(Mean Corpuscular Volume)<br>*Derived from RBC Histogram* | 84.3 | 83 - 101 | fL |
| MCH(Mean Corpuscular Hemoglobin)<br>*Calculated* | 28.7 | 27 - 32 | pg |
| MCHC(Mean Corpuscular Hemoglobin Concentration)<br>*Calculated* | 34.0 | 31.5 - 34.5 | g/dL |
| RDW<br>*Derived from RBC Histogram* | 13.3 | 11.6 - 14 | % |
| Total Leukocyte Count<br>*coulter principle* | 5.5 | 4.0 - 10.0 | $10^3$/µl |
| **Differential count % (VCSn & Microscopy)** | | | |
| Neutrophils | 54.0 | 40-80 | % |
| Lymphocytes | 36.0 | 20-40 | % |
| Monocytes | 8.0 | 2-10 | % |
| Eosinophils | 2.0 | 1-6 | % |
| Basophils | 0.0 | 0-1 | % |
| **Differential Counts, Absolute(calculated)** | | | |
| Absolute Neutrophil Count | 2.97 | 2.0-7.0 | $10^3$/µl |
| Absolute Lymphocyte Count | 1.98 | 1.0-3.0 | $10^3$/µl |
| Absolute Monocyte Count | 0.44 | 0.2 - 1.0 | $10^3$/µl |
| Absolute Eosinophil Count (AEC) | 0.11 | 0.02-0.5 | $10^3$/µl |
| Platelet Count<br>*coulter principle* | 255 | 150 - 410 | $10^3$/µl |
| MPV<br>*Derived from platelet histogram* | 7.6 | 7.5 - 11.5 | fL |



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| GENDER | : Female | **LAB MR#** | **: AAZ400000018** | RECEIVED ON | : 20-04-2026 17:40 |
| OP / IP / DG # | : | | | APPROVED ON | : 20-04-2026 18:59 |
| | | | | REPORT STATUS | : Final Report |

| Test Name | Result | Biological Ref. Interval | Unit |
|---|---|---|---|
| **Am-Fit Senior Citizen - Female** | | | |
| | **BIOCHEMISTRY** | | |
| **Lipid profile** *(Serum)* | | | |
| Cholesterol Total - Serum<br>*Enzymatic colorimetric* | 165.0 | No risk: <200<br>Moderate risk: 200-239<br>High risk: >240 | mg/dL |
| Triglycerides<br>*Enzymatic colorimetry* | 105.0 | Normal: <150<br>Borderline-high: 150–199<br>High risk 200–499<br>Very high risk >500 | mg/dL |
| Cholesterol - HDL (Direct)<br>*Enzymatic colorimetric* | 62.0 | High Risk: <40<br>No Risk: >60 | mg/dL |
| LDL Chol, Calculated | 82.00 | Optimal:<100<br>Near optimal:100 - 129<br>Borderline high:130-159<br>High risk:160 - 189 | mg/dL |
| VLDL (Very Low Density Lipoprotein)<br>*Calculation* | 21.0 | <30 | mg/dL |
| Cho/HDL Ratio<br>*Enzymatic colorimetric & Calculation* | 2.66 | Normal:<4.0<br>Low risk:4.0-6.0<br>High risk:>6.0 | |
| LDL/HDL Ratio | 1.32 | Desirable/Low Risk: 0.5 - 3.0<br>Borderline/Moderate: 3.1 - 6.0<br>High Risk: >6.0 | |
| **LFT(Bilirubin Total, Bilirubin Conjugated,** *(Serum)* | | | |
| Bilirubin Total<br>*Diazo method* | 0.50 | <1.1 | mg/dL |
| Bilirubin Conjugated<br>*Diazo method* | 0.2 | <=0.2 | mg/dL |
| Bilirubin Unconjugated, Indirect<br>*Calculation* | 0.30 | <1.0 | mg/dL |
| Aspartate Aminotransferase (AST/SGOT)<br>*IFCC kinetic* | 26 | < 32 | U/L |
| Alanine aminotransferase - (ALT / SGPT)<br>*Kinetic IFCC* | 22 | < 33.0 | U/L |
| Alkaline Phosphatase - ALP<br>*IFCC kinetic* | 79.0 | <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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| 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)<br>*Calculation* | 14.49 | 7-19 | mg/dL |
| **Creatinine** *(Serum)* | | | |
| Creatinine<br>*Modified Jaffe Kinetic* | 0.8 | 0.50 - 0.90 | mg/dL |
| **Urea** *(Serum)* | | | |
| Urea<br>*Kinetic, Urease* | 31.0 | 19.0 - 49.0 | mg/dL |
| **Uric acid** *(Serum)* | | | |
| Uric acid<br>*Uricase* | 5.4 | 2.3 - 6.1 | mg/dL |



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| Test Name | Result | Biological Ref. Interval | Unit |
|---|---|---|---|
| **Am-Fit Senior Citizen - Female** | | | |
| **CLINICAL PATHOLOGY** | | | |
| **Urine Examination - Routine & Microscopy (CUE)** *(Urine)* | | | |
| **PHYSICAL EXAMINATION:** | | | |
| Volume | 15.00 | | mL |
| Colour | Pale Yellow | Pale | |
| Appearance | Clear | Clear | |
| **CHEMICAL EXAMINATION:** | | | |
| pH<br>*Dip stick* | 6.50 | 4.8 - 7.4 | |
| Specific Gravity<br>*Dip Stick(Bromothymol blue)* | 1.015 | 1.010 - 1.022 | |
| Protein<br>*Dip Stick/ Sulfosalicylic acid* | Negative | Negative | |
| Glucose<br>*Dip Stick /Benedicts test* | Negative | Negative | |
| Ketones<br>*Dip stick/Sodium nitroprusside reaction* | Absent | Negative | |
| Urobilinogen<br>*Dip Stick / Ehrlich reaction* | Normal | Normal | |
| Leucocyte Esterase<br>*Dip Stick* | Negative | Negative | |
| Nitrite<br>*Dip Stick / (Griess test )* | Negative | Negative | |
| Bilirubin<br>*Dipstick/diazo* | Negative | Negative | |
| Blood<br>*Dip Stick ( Peroxidase)* | Not Detected | Negative | |
| **Microscopic Examination** | | | |
| Pus Cells | 1 - 2 | 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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|---|---|---|---|
| **Am-Fit Senior Citizen - Female** | | | |
| **BIOCHEMISTRY** | | | |
| **Calcium - Serum** *(Serum)* | | | |
| Calcium - Serum<br>*NM-BAPTA* | 9.10 | 8.6 - 10.0 | mg/dL |
| **Vitamin B12** *(Serum)* | | | |
| Vitamin B12<br>*ECLIA* | 645.00 | 197-771 | pg/mL |

**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 gastrostomy, 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<br>*ECLIA* | 54.0 | Deficient: <=20<br>Insufficiency: 20-29<br>Desirable: >=30-100<br>Toxicity: >100 | ng/ml |

**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 cab be due to -** increased vit D supplements intake

| | | | |
|---|---|---|---|
| **HbA1c - Glycated Hemoglobin** *(Whole Blood - EDTA)* | | | |
| Glycated Hemoglobin, HbA1c<br>*HPLC* | 5.10 | Non diabetic range: 4.8-5.6<br>Prediabetic range: 5.7-6.4<br>Diabetes range: >=6.5 | % |
| Estimated Average Glucose | 99.7 | | 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 | 89.0 | Normal : 74-100 | mg/dL |



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| **Am-Fit Senior Citizen - Female** | | | |
| *Hexokinase* | | Pre-diabetic : 100-125<br>Diabetic: >=126 | |
| **T3 - Total (Tri Iodothyronine)** *(Serum)* | | | |
| T3 - Total (Tri Iodothyronine)<br>*ECLIA* | 174.0 | 80.00 - 200.00 | ng/dL |
| **T4 - Total (Thyroxine - Total)** *(Serum)* | | | |
| T4 - Total (Thyroxine - Total)<br>*ECLIA* | 13.00 | 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<br>*ECLIA* | 4.000 | Non pregnant women: 0.27-4.2<br>Pregnant women<br>1st trimester: 0.1-2.5<br>2nd trimester: 0.2-3.0<br>3rd trimester: 0.3-3.0 | µIU/mL |

**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.



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| **Am-Fit Senior Citizen - Female** | | | |
| **Iron Binding Capacity - Total (TIBC)** *(Serum)* | | | |
| Iron<br>*FerroZine Colorimetric Assay* | 102.0 | 59-158 | µg/dL |
| Unsaturated Iron Binding Capacity (UIBC)<br>*Direct determination with FerroZine* | 285.0 | 125 - 345 | µg/dL |
| Iron Binding Capacity - Total (TIBC)<br>*Calculation* | 387.0 | 228-428 | µg/dL |
| Transferrin Saturation Index (TSI)<br>*Calculation* | 26.4 | 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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| GENDER | : Female | **LAB MR#** | **: AAZ400000018** | RECEIVED ON | : 20-04-2026 18:25 |
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| Test Name | Result | Biological Ref. Interval | Unit |
|---|---|---|---|
| **Am-Fit Senior Citizen - Female** | | | |
| **SEROLOGY AND IMMUNOLOGY** | | | |
| **Hepatitis B Surface antigen (HBsAg) - Spot Test** *(Serum)* | | | |
| Hepatitis B Surface antigen (HBsAg) - Spot Test<br>*Immunochromatography* | Negative | Negative | |

**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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| **Am-Fit Senior Citizen - Female** | | | |
| **BIOCHEMISTRY** | | | |
| **Ferritin** *(Serum)* | | | |
| Ferritin<br>*ECLIA* | 245.00 | 30-400 | ng/mL |

**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

| | | | |
|---|---|---|---|
| **CA 125 (Cancer Antigen 125)** *(Serum)* | | | |
| CA 125<br>*ECLIA* | 24.00 | < 35 | U/mL |

**Interpretation:**

CA 125 is a high molecular mass glycoprotein. Expresses by epithelial ovarian tumors and other pathological and normal tissues of mullerian duct origin. CA 125 found in a high percentage of ovarian tumors of epithelial origin and useful to monitor cancer treatment, to check for recurrence.

**Elevated values are found in cases of:**

Endometriosis, Ovarian cyst, early pregnancy, benign disease like pancreatitis, cirrhosis, hepatitis & other malignancies of endometrium, breast, gastrointestinal tract, lung etc.,



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**Am-Fit Senior Citizen - Female**

Dr. Sanjeeta
MBBS,MD (Biochemistry)
Consultant Biochemist

Dr. G. Amitha
MBBS, MD (MICROBIOLOGY)
Consultant Microbiologist

Dr. Praveena P
MBBS, MD Pathology
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 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.



**Sin No: 20385064,20385065,20385066,20385067**