Thyrocare

Tests you can trust

Name : XXX XXX XXX

Date : XXX XXX

Test Asked : Senior Citizen Wellness Master

Report Status : Complete Report

Processed At :
D-37/1,TTC MIDC,Turbhe, Navi
Mumbai - 400703

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Tests you can trust

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Patient Name	: **XXX XXX XXX**	Tests Done	: **SENIOR CITIZEN WELLNESS MASTER**
Referred By	: **SELF**		
Address	: **XXX XXX XXX XXX XXX**		

Report Availability Summary

Note: Please refer to the table below for status of your tests.

37 Ready | **0** Ready with Cancellation | **0** Processing | **0** Cancelled in Lab

TEST DETAILS	REPORT STATUS
SENIOR CITIZEN WELLNESS MASTER	Ready
FASTING BLOOD SUGAR(GLUCOSE)	Ready
CHLORIDE	Ready
25-OH VITAMIN D (TOTAL)	Ready
CYSTATIN C	Ready
FERRITIN	Ready
FRUCTOSAMINE	Ready
HOMOCYSTEINE	Ready
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	Ready
INSULIN - FASTING	Ready
URINOGRAM	Ready
LIPASE	Ready
Lipoprotein (a) [Lp(a)]	Ready
MAGNESIUM	Ready
LP-PLA2	Ready
SERUM COPPER	Ready
SERUM ZINC	Ready
SODIUM	Ready
TESTOSTERONE	Ready
VITAMIN A	Ready
VITAMIN E	Ready
VITAMIN K	Ready
HBA PROFILE	Ready

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Patient Name	: **XXX XXX XXX**	Tests Done	: **SENIOR CITIZEN WELLNESS MASTER**
Referred By	: **SELF**		
Address	: **XXX XXX XXX XXX XXX**		

Report Availability Summary

Note: Please refer to the table below for status of your tests.

37 Ready | **0** Ready with Cancellation | **0** Processing | **0** Cancelled in Lab

TEST DETAILS	REPORT STATUS
HEMOGRAM - 6 PART (DIFF)	Ready
ANTI CCP (ACCP)	Ready
LIVER FUNCTION TESTS	Ready
ELEMENTS 22 (TOXIC AND NUTRIENTS)	Ready
IRON DEFICIENCY PROFILE	Ready
KIDPRO	Ready
LIPID PROFILE	Ready
VITAMIN B COMPLEX PROFILE	Ready
T3-T4-USTSH	Ready
URINE MICROALBUMIN	Ready
APOLIPROTEIN RATIO	Ready
AMYLASE	Ready
ANTI NUCLEAR ANTIBODIES (ANA)	Ready
BLOOD KETONE (D3HB)	Ready
PHOSPHOROUS	Ready

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Patient Name	: **XXX XXX XXX**	Tests Done	: **SENIOR CITIZEN WELLNESS MASTER**
Referred By	: **SELF**		
Address	: **XXX XXX XXX XXX XXX**		

Tests Outside Reference Range

Note: Please refer to the table below for tests outside reference range.

Test Name	Observed Value	Units	Bio. Ref. Interval.
CARDIAC RISK MARKERS			
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	**27.1**	mg/L	< 3
HOMOCYSTEINE	**32.79**	µmol/L	<15
COMPLETE HEMOGRAM			
BASOPHILS - ABSOLUTE COUNT	**0.11**	X 10³ / µL	0.02 - 0.1
HEMOGLOBIN	**12.5**	g/dL	13.0-17.0
LYMPHOCYTES - ABSOLUTE COUNT	**3.1**	X 10³ / µL	1.0-3.0
MEAN CORP.HEMO.CONC(MCHC)	**31**	g/dL	31.5-34.5
MEAN CORPUSCULAR HEMOGLOBIN(MCH)	**23.1**	pq	27.0-32.0
MEAN CORPUSCULAR VOLUME(MCV)	**74.5**	fL	83.0-101.0
NEUTROPHILS - ABSOLUTE COUNT	**7.7**	X 10³ / µL	2.0-7.0
RED CELL DISTRIBUTION WIDTH (RDW-CV)	**19.5**	%	11.6-14
RED CELL DISTRIBUTION WIDTH - SD(RDW-SD)	**48.5**	fL	39-46
TOTAL LEUCOCYTES COUNT (WBC)	**11.32**	X 10³ / µL	4.0 - 10.0
DIABETES			
AVERAGE BLOOD GLUCOSE (ABG)	**166**	mg/dL	90-120
FASTING BLOOD SUGAR(GLUCOSE)	**173.38**	mg/dL	70-100
FRUCTOSAMINE	**299.6**	µmol/L	<=286
HbA1c	**7.4**	%	< 5.7
ELECTROLYTES			
CHLORIDE	**97.2**	mmol/L	98 - 107
ELEMENTS			
SERUM COPPER	**158.2**	µg/dL	63.5 - 150
IRON DEFICIENCY			
% TRANSFERRIN SATURATION	**8.17**	%	13 - 45
FERRITIN	**15.4**	ng/mL	21.81 - 274.66
IRON	**36.5**	µg/dL	65 - 175
UNSAT.IRON-BINDING CAPACITY(UIBC)	**410.2**	µg/dL	162 - 368
LIPID			
HDL / LDL RATIO	**0.23**	Ratio	> 0.40
HDL CHOLESTEROL - DIRECT	**33**	mg/dL	40-60
LDL / HDL RATIO	**4.4**	Ratio	1.5-3.5
LDL CHOLESTEROL - DIRECT	**142**	mg/dL	< 100
NON-HDL CHOLESTEROL	**182.9**	mg/dL	< 160

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	: **XXX XXX XXX**	Tests Done	: **SENIOR CITIZEN WELLNESS MASTER**
Referred By	: **SELF**		
Address	: **XXX XXX XXX XXX XXX**		

Tests Outside Reference Range

Note: Please refer to the table below for tests outside reference range.

Test Name	Observed Value	Units	Bio. Ref. Interval.
TC/ HDL CHOLESTEROL RATIO	**6.6**	Ratio	3 - 5
TOTAL CHOLESTEROL	**216**	mg/dL	< 200
TRIG / HDL RATIO	**9.95**	Ratio	< 3.12
TRIGLYCERIDES	**325**	mg/dL	< 150
VLDL CHOLESTEROL	**64.9**	mg/dL	5 - 40
METABOLIC			
MAGNESIUM	**1.87**	mg/dL	1.90 - 3.10
PANCREATIC			
LIPASE	**64.5**	U/L	5.0 - 60.0
RENAL			
URIC ACID	**7.48**	mg/dL	4.2 - 7.3
URINE			
URI. ALBUMIN/CREATININE RATIO (UA/C)	**77.4**	µg/mg of Creatinine	< 30
URINARY MICROALBUMIN	**112.82**	µg/mL	< 25
URINOGRAM			
URINARY PROTEIN	**Trace (15-30 mg/dl)**	mg/dL	Absent
VITAMINS			
25-OH VITAMIN D (TOTAL)	**21.8**	ng/mL	30-100

Patient Name : XXX XXX XXX
Referred By : SELF
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : XXX XXX
Sample Received on (SRT) : XXX XXX
Report Released on (RRT) : XXX XXX
Sample Type | Barcode : SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval
TOTAL CHOLESTEROL	PHOTOMETRY	216	mg/dL	< 200
HDL CHOLESTEROL - DIRECT	PHOTOMETRY	33	mg/dL	40-60
LDL CHOLESTEROL - DIRECT	PHOTOMETRY	142	mg/dL	< 100
HDL / LDL RATIO	CALCULATED	0.23	Ratio	> 0.40
TRIGLYCERIDES	PHOTOMETRY	325	mg/dL	< 150
TRIG / HDL RATIO	CALCULATED	9.95	Ratio	< 3.12
TC/ HDL CHOLESTEROL RATIO	CALCULATED	6.6	Ratio	3 - 5
LDL / HDL RATIO	CALCULATED	4.4	Ratio	1.5-3.5
NON-HDL CHOLESTEROL	CALCULATED	182.9	mg/dL	< 160
VLDL CHOLESTEROL	CALCULATED	64.9	mg/dL	5 - 40

Please correlate with clinical conditions.

Method :

CHOL - Cholesterol Oxidase, Esterase, Peroxidase
HCHO - Direct Enzymatic Colorimetric
LDL - Direct Measure
HD/LD - Derived from HDL and LDL values.
TRIG - Enzymatic, End Point
TRI/H - Derived from TRIG and HDL Values
TC/H - Derived from serum Cholesterol and Hdl values
LDL/ - Derived from serum 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.

Dr xyz
MD(Path)

Dr XYZ
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN K	LC-MS/MS	0.32	ng/mL

Bio. Ref. Interval. :-

0.13 - 1.19

Clinical significance:

Vitamin K assay measures the principal form of vitamin K i.e. K1 :Phylloquinone which found predominantly in green leafy vegetables, margarines and plant oils.

Vitamin K promotes clotting of the blood, is required for the conversion of several clotting factors and prothombin, and is of growing interest in bone metabolism. Vitamin K plays important role in the deposition of ionic calcium needed for proper blood coagulation and bone formation.

Although vitamin K deficiency in the adults is uncommon, the risk is increased for fat malabsorption states such as bile duct obstruction,cystic fibrosis, chronic pancreatitis and liver disease. Risk also increased by the use of drugs that interfere with vitamin K metabolism, such as warfarin, cepahlosporin. Defective blood coagulation and demonstration of abnormal noncarboxylated prothrombin are at present the only well-established signs of vitamin K deficiency.

The use of high doses of naturally occurring vitamin K (K1 and K2) appears to have no untoward effect; however menadione(K3) treatment can lead to formation of erythrocyte cytoplasmic inclusions known as Heinz bodies and hemolytic anemia. With severe hemolysis, increase bilirubin formation and undeveloped capacity for its conjugation may produce kernicterus in the newborn.

Clinical reference:

Tietz Textbok of clinical chemistry and Molecular diagnostic, Carl A. Burtis, Edward R. Ashwood, David E. Bruns, Fifth edition., Elsevier.

Please correlate with clinical conditions.

Method:- LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr XYZ
MD(Path)

Dr XYZ
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN E	LC-MS/MS	16213.2	ng/mL

Bio. Ref. Interval. :-

Age < 1 Month	1000 - 3500
2 - 5 Months	2000 - 6000
6 M - 1 year	3500 - 8000
2 - 12 years	5500 - 9000
Above 13 years	5500 - 18000

Clinical Significance: Vitamin E or Alpha-tocopherol (body's main form of vitamin) function as antioxidant which protects vitamin A, C and red blood cells from oxidative damage caused by free radicals. It has been recognized as necessary for neurologic and reproductive functions, for prevention of retinopathy in premature infants. Alpha-tocopherol also induces inhibition of cell proliferation, platelete aggregation, and monocyte adhesion, which are thought to be the results of direct interaction of alpha-tocopherol with cell components. Alpha-tocopherol reduces inflammatory mediator production.

Premature and low birth weight infants are particularly susceptible to development of vitamin E deficiency, because placental transfer is poor and infants have such limited adipose tissue where much of the vitamins is normally stored. Signs of deficiency include irritability, edema and hemolytic anemia. Although symptoms of vitamin E deficiency are rare in children and adults, deficiency can occur in some conditions.

Excess vitamin E intake usually is achieved only by dietary supplementation. A comprehensive review of tolerance and safety of vitamin E suggested that intakes upto 3000mg/d were safe and reversible side effects of gastrointestinal symptoms, increased creatinuria, and impairment of blood coagulation are seen at intakes of 1000-3000 mg/d. However as noted earlier, long term use of intakes greater than 400mg/d may cause increased mortality.

Clinical reference: Tietz Textbok of clinical chemistry and Molecular diagnostic, Carl A. Burtis, Edward R. Ashwood, David E. Bruns, Fifth edition., Elsevier.

Please correlate with clinical conditions.

Method:- LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

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Referred By	: SELF	**Sample Received on (SRT)**	: XXX XXX
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: XXX XXX
		Sample Type | Barcode	: SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
25-OH VITAMIN D (TOTAL)	**E.C.L.I.A**	**21.8**	**ng/mL**

Bio. Ref. Interval. :
Deficiency : <=20 ng/ml || Insufficiency : 21-29 ng/ml
Sufficiency : >= 30 ng/ml || Toxicity : >100 ng/ml

Clinical Significance:
Vitamin D is a fat soluble vitamin that has been known to help the body absorb and retain calcium and phosphorous; both are critical for building bone health.
Decrease in vitamin D total levels indicate inadequate exposure of sunlight, dietary deficiency, nephrotic syndrome.
Increase in vitamin D total levels indicate Vitamin D intoxication.

Specifications: Precision: Intra assay (%CV):9.20%, Inter assay (%CV):8.50%
Kit Validation Reference : Holick M. Vtamin D the underappreciated D-Lightful hormone that is important for Skeletal and cellular health Curr Opin Endocrinol Diabetes 2002:9(1)87-98.

Method : Fully Automated Electrochemiluminescence Compititive Immunoassay

Please correlate with clinical conditions.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

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Dr XYZ MD(Path)

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Referred By : SELF
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : XXX XXX
Sample Received on (SRT) : XXX XXX
Report Released on (RRT) : XXX XXX
Sample Type | Barcode : SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval
VITAMIN B1/THIAMIN	LC-MS/MS	0.63	ng/mL	0.5-4.0
VITAMIN B-12	E.C.L.I.A	374	pg/mL	197-771
VITAMIN B2/RIBOFLAVIN	LC-MS/MS	10.18	ng/mL	1.6-68.2
VITAMIN B3/NICOTINIC ACID	LC-MS/MS	2.24	ng/mL	< 5
VITAMIN B5/PANTOTHENIC	LC-MS/MS	76.74	ng/mL	11-150
VITAMIN B6/P5P	LC-MS/MS	6.25	ng/mL	5 - 50
VITAMIN B7/BIOTIN	LC-MS/MS	0.56	ng/mL	0.2-3
VITAMIN B9/FOLIC ACID	LC-MS/MS	0.64	ng/mL	0.2-20

Please correlate with clinical conditions.

Method :

VITB1 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB - Fully Automated Electrochemiluminescence Compitive Immunoassay
VITB2 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB3 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB5 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB6 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB7 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
VITB9 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN A	LC-MS/MS	383.82	ng/mL

Bio. Ref. Interval. :-

Age	Reference range
1 - 6 Years	200 - 400
7 - 12 Years	260 - 490
13 - 19 Years	260 - 720
Above 18 Years	300 - 800

Clinical Significance:

Vitamin A or Retinol plays important role in the function retinal vision, growth, reproduction, embryonic development as well as in immune function.Vitamin A is also required for adaptive immunity and plays a role in the development of both T- helper cells and B-cells. Retinol and its metabolites and synthetic retinoids provide protective effects against the development of certain types of cancer by blocking tumor promotion, by inhibiting proliferation,by inducing apoptosis, by inducing differentiation or by performing combination of these actions.

Fat malabsorption, particularly caused by celiac disease or chronic pancreatitis and protein -energy malnutrition predispose to vitamin A deficiency.Clinical features of vitamin A deficiency include degenerative changes in eyes and skin and poor dark adaptation or night blindness.Vitamin A deficiency impairs innate immunity by impeding normal regeneration of mucosal bariers damaged by infection and by diminishing the function of neutrophils,macrophages and natural killer cells.

Toxic effects of hypervitaminosis A have occurred as a result of ingestion of excess vitamin or as a side effect of inappropriate therapy.Symptoms of acute toxicity from single massive dose present as abdominal pain,nausea,vomiting,severe headache, dizziness,sluggishness and irritability.Chronic toxicity shows symptoms like bone, join pain, hair loss, dryness and fissures of the lips, anorexia, benign intracranial hypertension, weight loss an hepatomegaly.

Clinical reference:

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Please correlate with clinical conditions.

Method:- LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TOTAL TRIIODOTHYRONINE (T3)	E.C.L.I.A	121	ng/dL	80-200
TOTAL THYROXINE (T4)	E.C.L.I.A	7.96	µg/dL	4.8-12.7
TSH - ULTRASENSITIVE	E.C.L.I.A	2.57	µIU/mL	0.54-5.30

Comments : ***

The Biological Reference Ranges is specific to the age group. Kindly correlate clinically.

Method :

T3,T4 - Fully Automated Electrochemiluminescence Compititive Immunoassay
USTSH - Fully Automated Electrochemiluminescence Sandwich Immunoassay

Disclaimer : Results should always be interpreted using the reference range provided by the laboratory that performed the test. Different laboratories do tests using different technologies, methods and using different reagents which may cause difference. In reference ranges and hence it is recommended to interpret result with assay specific reference ranges provided in the reports. To diagnose and monitor therapy doses, it is recommended to get tested every time at the same Laboratory.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

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Patient Name : XXX XXX XXX
Referred By : SELF
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : XXX XXX
Sample Received on (SRT) : XXX XXX
Report Released on (RRT) : XXX XXX
Sample Type | Barcode : SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval
UREA (CALCULATED)	CALCULATED	24.74	mg/dL	Adult : 17-43
BLOOD UREA NITROGEN (BUN)	PHOTOMETRY	11.56	mg/dL	7.94 - 20.07
UREA / SR.CREATININE RATIO	CALCULATED	32.99	Ratio	< 52
CREATININE - SERUM	PHOTOMETRY	0.75	mg/dL	0.72-1.18
BUN / SR.CREATININE RATIO	CALCULATED	15.41	Ratio	9:1-23:1
CALCIUM	PHOTOMETRY	9.95	mg/dL	8.8-10.6
URIC ACID	**PHOTOMETRY**	**7.48**	**mg/dL**	**4.2 - 7.3**
SODIUM	I.S.E - INDIRECT	138.4	mmol/L	136 - 145
CHLORIDE	**I.S.E - INDIRECT**	**97.2**	**mmol/L**	**98 - 107**

Please correlate with clinical conditions.

Method :

UREAC - Derived from BUN Value.
BUN - Kinetic UV Assay.
UR/CR - Derived from UREA and Sr.Creatinine values.
SCRE - Creatinine Enzymatic Method
B/CR - Derived from serum Bun and Creatinine values
CALC - Arsenazo III Method, End Point.
URIC - Uricase / Peroxidase Method
SOD - ION SELECTIVE ELECTRODE - INDIRECT
CHL - ION SELECTIVE ELECTRODE - INDIRECT

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Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : XXX XXX
Sample Received on (SRT) : XXX XXX
Report Released on (RRT) : XXX XXX
Sample Type | Barcode : SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
IRON	**PHOTOMETRY**	**36.5**	**µg/dL**
Bio. Ref. Interval. : Male : 65 - 175 Female : 50 - 170			
Method : Ferrozine method without deproteinization			
TOTAL IRON BINDING CAPACITY (TIBC)	PHOTOMETRY	446.7	µg/dL
Bio. Ref. Interval. : Male: 225 - 535 µg/dl Female: 215 - 535 µg/dl			
Method : Spectrophotometric Assay			
% TRANSFERRIN SATURATION	**CALCULATED**	**8.17**	**%**
Bio. Ref. Interval. : 13 - 45			
Method : Derived from IRON and TIBC values			
FERRITIN	**C.M.I.A**	**15.4**	**ng/mL**
Bio. Ref. Interval. : Men: 21.81 - 274.66 ng/ml Women: 4.63 - 204.00 ng/ml			
Method : Fully Automated Chemi Luminescent Microparticle Immunoassay			
UNSAT.IRON-BINDING CAPACITY(UIBC)	**PHOTOMETRY**	**410.2**	**µg/dL**
Bio. Ref. Interval. : 162 - 368			
Method : SPECTROPHOTOMETRIC ASSAY			

Please correlate with clinical conditions.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

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MD(Path)

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Report Released on (RRT) : XXX XXX
Sample Type | Barcode : SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
TESTOSTERONE	E.C.L.I.A	493	ng/dL

Bio. Ref. Interval. :-

280 - 800

Clinical Significance: Clinical evaluation of serum testosterone, along with serum LH, assists in evaluation of Hypogonadal males. Major causes of lowered testosterone in males include Hypogonadotropic hypogonadism, testicular failure Hyperprolactinema, Hypopituitarism some types of liver and kidney diseases and critical illness.

Specifications: Precision: Intra assay (%CV): 11.50 %, Inter assay (%CV): 5.70%; Sensitivity: 7 ng/dL.
Kit Validation Reference: Wilson JD Foster DW (Eds) Williams Textbook of Endocrinology 8th Edition WB Saunders Piladelphia Pennsylvania.

Note : The Biological Reference Range mentioned is specific to the age group and gender. Kindly correlate clinically.

Please correlate with clinical conditions.
Method:- Fully Automated Electrochemiluminescence Compititive Immunoassay

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

Scan QR to verify(valid for 30 days from release time)

Patient Name : **XXX XXX XXX**
Referred By : **SELF**
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : **XXX XXX**
Sample Received on (SRT) : **XXX XXX**
Report Released on (RRT) : **XXX XXX**
Sample Type | Barcode : **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval
ALKALINE PHOSPHATASE	PHOTOMETRY	89.4	U/L	45-129
BILIRUBIN - TOTAL	PHOTOMETRY	0.63	mg/dL	0.3-1.2
BILIRUBIN -DIRECT	PHOTOMETRY	0.14	mg/dL	0 - 0.20
BILIRUBIN (INDIRECT)	CALCULATED	0.49	mg/dL	0-0.9
GAMMA GLUTAMYL TRANSFERASE (GGT)	PHOTOMETRY	43.1	U/L	< 55
ASPARTATE AMINOTRANSFERASE (SGOT)	PHOTOMETRY	23.8	U/L	< 35
SGOT / SGPT RATIO	CALCULATED	1.38	Ratio	< 2
ALANINE TRANSAMINASE (SGPT)	PHOTOMETRY	17.2	U/L	< 45
PROTEIN - TOTAL	PHOTOMETRY	7.41	gm/dL	5.7-8.2
ALBUMIN - SERUM	PHOTOMETRY	4.18	gm/dL	3.2-4.8
SERUM GLOBULIN	CALCULATED	3.23	gm/dL	2.5-3.4
SERUM ALB/GLOBULIN RATIO	CALCULATED	1.29	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
OT/PT - Derived from SGOT and SGPT values.
SGPT - IFCC* Without Pyridoxal Phosphate Activation
PROT - Biuret Method
SALB - Albumin Bcg¹method (Colorimetric Assay Endpoint)
SEGB - DERIVED FROM SERUM ALBUMIN AND PROTEIN VALUES
A/GR - Derived from serum Albumin and Protein values

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
SERUM ZINC	PHOTOMETRY	98.22	µg/dL

Bio. Ref. Interval. :-

70 - 115

Clinical Significance:
Zinc is one of the essential trace elements in the body. Its metalloenzymes play a key role in protein and nucleic acid synthesis, gene expression, wound healing, as an antioxidant, etc. Deficiency can cause- Poor wound healing, gastroenteritis, impaired spermatogenesis, Alzheimer's disease, etc. Toxicity may be manifested as pancreatitis, gastric ulcer, anemia, pulmonary fibrosis.

Specifications:
Precision: Intra assay (%CV): 2.02, Inter assay (%CV): 2.22.

Kit Validation References:
Thomas L. Clinical Laboratory Diagnostics. 1st ed. Frankfurt: TH-Books Verlagsgesellschaft; 1998. p. 347-9

Please correlate with clinical conditions.
Method:- NITRO - PAPS

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
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		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
SERUM COPPER	**PHOTOMETRY**	**158.2**	**µg/dL**

Bio. Ref. Interval. :-

Male : 63.5 - 150
Female : 80 - 155

Clinical significance:
Copper is an important trace element and a component of numerous enzymes and proteins involved in energy production, connective tissue formation, melanin synthesis, iron metabolism, development of central nervous system, angiogenesis as well as an antioxidant. Deficiency can cause- Malnourishment, cardiovascular disease, anemia & neuropathy, toxicity may be manifested as acute renal failure, gastroenteritis & chronic liver disease.

Specifications:
Precision: Intra assay (%CV): 1.17, Inter assay (%CV): 2.32.

Kit validation references:
Thomas L. Clinical Laboratory Diagnostics. 1st ed. Frankfurt: TH-Books Verlagsgesellschaft; 1998. p. 337-8

Please correlate with clinical conditions.
Method:- 3,5-DIBR-PAESA

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
LP-PLA2	PHOTOMETRY	142	nmol/min/mL

Bio. Ref. Interval. :-

Low Risk : < 225 nmol/min/mL
High Risk : >= 225 nmol/min/mL

Clinical Significance:

Lp-PLA2, is an enzyme produced by inflammatory cells. It is predominantly associated with low-density lipoprotein (LDL) and high-density lipoprotein (HDL). Lp-PLA2 is a specific marker of vascular inflammation and found to be upregulated in atherosclerotic lesions especially in complex plaque prone to rupture. A meta-analysis found that Lp-PLA2 levels are positively correlated with increased risk of developing coronary heart disease and stroke. Lp-PLA2 is not an acute phase reactant and thus is unaffected by systemic inflammatory processes. Lp-PLA2 activity should be interpreted in conjunction with clinical evaluation and other risk factor assessment.

Specification:

Precision %CV : Intra assay %CV- 1.50% , Inter assay %CV-3.80%

Kit Validation Reference:

Alexander Thompson etal., The Lp-PLA2 Studies Collaboration (2010). "Lipoprotein-associated phospholipase A2 and risk of coronary disease, stroke, and mortality: collaborative analysis of 32 prospective studies". The Lancet 375 (9725): 1536-1544

Please correlate with clinical conditions.
Method:- ENZYMATIC ASSAY

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
PHOSPHOROUS	PHOTOMETRY	4.23	mg/dL

Bio. Ref. Interval. :
Adults : 2.4 - 5.1 mg/dL
Children : 4.0 - 7.0 mg/dL

Clinical Significance:
In plasma and serum the majority of phosphate exists in the inorganic form (Pi), approximately 15% bound to protein and the remainder in complexes and free forms. Serum phosphate concentrations are dependent on diet and variation in the secretion of hormones such as Parathyroid Hormone (PTH).

Specifications:
Precision %CV :- Intra assay %CV- 1.55% , Inter assay %CV-2.99% , Sensitivity:-0.10 mmol/L

Kit Validation Reference:
Young DS. Effects of drugs on clinical laboratory tests, 5th ed. AACC Press, 2000.

Method : UNREDUCED PHOSPHOMOLYBDATE METHOD

Please correlate with clinical conditions.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
MAGNESIUM	**PHOTOMETRY**	**1.87**	**mg/dL**

Bio. Ref. Interval. :-

1.90 - 3.10 mg/dL

Clinical significance:

Magnesium is the fourth most abundant cation in the body and second most prevalent intracellular cation. The total body magnesium content is about 25 g or approximately 1 mol, of which 55% reside in the skeleton. About 45% of the magnesium is intracellular. In general higher the metabolic activity of cell, the greater is its magnesium content. Magnesium is a cofactor for more than 300 enzymes in the body.

Disorders of magnesium metabolism are separated into those causing hypomagnesaemia/magnesium deficiencies and hypermagnesemia. Hypomagnesaemia is common in patient in hospitals. Moderate to severe deficiency of magnesium is usually due to loss of magnesium from the gastrointestinal (gi) tract or kidneys. One of the more serious complications of magnesium deficiency is cardiac arrhythmia. Symptomatic hypermagnsemia is almost always caused by excessive intake, resulting from administration of antacids, enemas, and parenteral fluids containing magnesium. Depression of neuromuscular system is the most common manifestation of magnesium intoxication.

External quality control program participation:

College Of American Pathologists: Chemistry survey; CAP Number: 7193855-01

Please correlate with clinical conditions.

Method:- MODIFIED XYLIDYL BLUE REACTION METHOD

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
Lipoprotein (a) [Lp(a)]	IMMUNOTURBIDIMETRY	23.9	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

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
LIPASE	**PHOTOMETRY**	**64.5**	**U/L**

Bio. Ref. Interval. :-

Adults : 5.0 - 60.0 U/L

Interpretation:

For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings like serum amylase. Serum Lipase is usually normal in patients with elevated serum amylase, having peptic ulcer, salivary adenitis, inflammatory bowel disease, intestinal obstruction, and macroamylasemia. Lipemic sera may interfere with results.

Clinical Significance:
High serum Lipase is a specific marker for pancreatitis; after acute pancreatitis the Lipase activity increases within 4-8 hours, reaches a peak after 24 hours and decreases after 8 to 14 days. However, there is no correlation between the Lipase activity determined in serum and the extent of damage to the pancreas.

Specifications:
Precision: Intra assay (%CV): 3.35, Inter assay (%CV): 2.46, Sensitivity: 3.5 U/L.

Kit Validation References:
Tietz Nw Et Al. Lipase In Serum - The Elusive Enzyme: An Overview. Clin Chem 1993; 39:746-756.

Please correlate with clinical conditions.
Method:- ENZYMATIC COLORIMETRIC ASSAY

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
INSULIN - FASTING	C.L.I.A	7.76	µU/mL

Bio. Ref. Interval. :-

1.9-23 µU/mL

Clinical Significance

Type I (Insulin dependent: "Juvenile") diabetes is due to a destruction of the beta cells, with a consequence of absolute lack of insulin. In type II (Non insulin-dependent: "Maturity onset") diabetes, insulin resistance may play an important role; However after several years of evolution, beta-cells failure may occur, leading to a relative insulinopenia requiring, in some cases, insulin administration. Insulin resistance is associated with high circulation levels of the hormone.

For diagnostic purpose, results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

Specifications:

Precision: Intra Assay (%CV): 4.20 %, Inter Assay (%CV): 5.60%; Sensitivity: 0.03 µU/mL

External quality control program participation:

College Of American Pathologists: Insulin Survey (Ing): Cap Number: 7193855-01

Kit validation references:

Howanitz PJ, Howanitz JH, Henry JB. Carbohydrates.Clinical Diagnosis and Management by Laboratory Methods 1991 ;172-182.edited by Henry JB, Philadelphia, W.B Saunders Company.

Please correlate with clinical conditions.

Method:- One step Immunoenzymatic (Sandwich) assay.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	**IMMUNOTURBIDIMETRY**	**27.1**	**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

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
HOMOCYSTEINE	**PHOTOMETRY**	**32.79**	**µmol/L**

Bio. Ref. Interval. :-

Normal Levels : <15 µmol/L
Mild Hyperhomocysteinemia : 15-30 µmol/L
Moderate Hyperhomocysteinemia : 30-100 µmol/L
Severe Hyperhomocysteinemia : >100 µmol/L

Clinical Significance:
Homocysteine is linked to increased risk of premature coronary artery disease, stroke and thromboembolism. Moreover, alzheimers disease, osteoporosis, venous thrombosis, schizophrenia, cognitive deficiency and pregnancy complications also elevates Homocysteine levels. The results should be interpreted in conjunction with clinical history and other findings.

High Values:
Elevated homocysteine levels might be due to increasing age, genetic traits, drugs, renal dysfunction and dietary deficiency of vitamins or smoking. To lower your homocysteine, eat more green vegetables, stop smoking, alcohol. Folic acid helps lowering elevated levels.

Specifications:
Kit Validation Reference:
Eikelboom JW, et al Ann Intern Med 131 : 363-75 (1999)
https://www.healthline.com/health/homocysteine-levels

Please correlate with clinical conditions.
Method:- SMALL MOLECULE CAPTURE TECHNOLOGY (SMT)

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
FRUCTOSAMINE	**PHOTOMETRY**	**299.6**	**µmol/L**

Bio. Ref. Interval. :-

Normal < 286 µmol/L

Clinical Significance:

Fructosamine assay is useful in monitoring the degree of glycemia over short-to-intermediate time frames (1-3 weeks) concentration greater than the established normal range is an indication of prolonged hyperglycemia of 1-3 weeks or longer. The higher fructosamine value, poorer is the degree of glycemia control.

Specifications:

Precision %CV : Intra assay %CV- 3.2% , Inter assay %CV-4.0%, Sensitivity:- 290 umol/L

Kit Validation Reference:

Howey JEA, Browning MCK, Fraser CG. Assay of serum fructosamine that minimizes standardization and matrix problems: Use to assess components of biological va-riation. Clin Chem 1987; 33: 269- 272.

Please correlate with clinical conditions.

Method:- NITROBLUE TETRAZOLIUM ASSAY (NBT)

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
EST. GLOMERULAR FILTRATION RATE (eGFR)	CALCULATED	100	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

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
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Referred By : **SELF**
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : **XXX XXX**
Sample Received on (SRT) : **XXX XXX**
Report Released on (RRT) : **XXX XXX**
Sample Type | Barcode : **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
CYSTATIN C	IMMUNOTURBIDIMETRY	1.29	mg/L

Bio. Ref. Interval. :-

<= 60 years: <= 1.03 mg/L
> 60 years : < 1.50 mg/L

Clinical significance

Cystatin c, is a small 13-kda protein and is a member of the cysteine proteinase inhibitor family, it is produced at a constant rate by all nucleated cells. Due to its small size it is freely filtered by the glomerulus and is not secreted but is fully reabsorbed and broken down by the renal tubules. This means that the primary determinate of blood Cystatin c levels is the rate at which it is filtered at the glomerulus making it an excellent gfr marker. Cystatin c is also a marker of inflammation and like many other markers of inflammation; its serum concentration may be higher in patients with decreased renal clearance. There is mounting evidence, however, that Cystatin c may be a predictor of adverse outcomes independent of renal function with its higher sensitivity to detect a reduced GFR than Creatinine determination, also in the so-called "Creatinine-blind" range. Thus, Cystatin c is suggested to be a better marker for GFR than the ubiquitous serum Creatinine.

Reference

1. Barrett aj, Davies me, Grubb a. the place of human gamma-trace (Cystatin c) among the cysteine proteinase inhibitors. Biochem biophys res common 1984; 120: 631-6.

2. Grubb a. diagnostic value of analysis of Cystatin c and protein HC in biological fluids. Clin Nephrol 1992; 38: S20-7.

Please correlate with clinical conditions.
Method:- LATEX ENHANCED IMMUNOTURBIDIMETRY

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Referred By	: **SELF**	**Sample Received on (SRT)**	: **XXX XXX**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **XXX XXX**
		Sample Type | Barcode	: **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
BLOOD KETONE (D3HB)	PHOTOMETRY	0.67	mg/dL

Bio. Ref. Interval. :-

0.21-2.81 mg/dL

Clinical Significance:
Three types of ketones can be produced in body D-3- Hydroxybutyrate, Acetoacetate and Acetone. D-3- Hydroxybutyrate accounts for approximately 75% of the ketone bodies. During periods of ketosis, D-3- Hydroxybutyrate increases more than the other two. It has been shown to be a better index of ketoacidosis. In diabetics, D-3- Hydroxybutyrate is needed for the assessment of the severity of diabetic coma and to calculate insulin requirements.

Speficcation:
Precision: Intra assay (%CV): 4.53, Inter assay (%CV): 2.9, Sensitivity: 10.41 mg/dL.

Kit validation references:
Mcmurray, C.H., Blanchflower, W.J., Rice, D.A., ClinChem., 1984;30:No.3.

Please correlate with clinical conditions.
Method:- ENZYMATIC (KINETIC)

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

Scan QR to verify(valid for 30 days from release time)

Patient Name : **XXX XXX XXX**
Referred By : **SELF**
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : **XXX XXX**
Sample Received on (SRT) : **XXX XXX**
Report Released on (RRT) : **XXX XXX**
Sample Type | Barcode : **SERUM | XXX**

TEST NAME	TECHNOLOGY	VALUE	UNITS
APOLIPOPROTEIN - A1 (APO-A1)	IMMUNOTURBIDIMETRY	104	mg/dL

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

Method : FULLY AUTOMATED RATE IMMUNOTURBIDIMETRY – BECKMAN COULTER

APOLIPOPROTEIN - B (APO-B)	IMMUNOTURBIDIMETRY	124	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	1.2	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.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

Scan QR to verify(valid for 30 days from release time)

Patient Name : XXX XXX XXX
Referred By : SELF
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : XXX XXX
Sample Received on (SRT) : XXX XXX
Report Released on (RRT) : XXX XXX
Sample Type | Barcode : SERUM | XXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
ANTI NUCLEAR ANTIBODIES (ANA)	C.M.I.A	< 1	AU/mL

Bio. Ref. Interval. :
Negative : <= 20 AU/mL
Positive : >20 AU/mL

Clinical Significance :
- ANA IgG assay is used as an aid in the diagnosis of autoimmune diseases, such as systemic lupus erythematosus, Sjogren syndrome, systemic sclerosis, polymyositis/dermatomyositis, mixed connective tissue disease and other diseases
- They are a heterogenous group of autoantibodies directed against Sm, nRNP/Sm, SS-A/Ro, SS-B, Jo-1, dsDNA, ribosome protein, histone, CENP-B and Scl-70.
- Antinuclear antibodies may also be detectable following viral illnesses, in individuals with chronic infections, or in patients treated with many different medications.
- Heterophilic antibodies and RF in samples may interfere with test results. Patients routinely exposed to animals or animal serum products can be prone to this interference
- Patients who have received mouse monoclonal antibodies can develop HAMA (human Anti-mouseantibodies), which can produce either falsely high or low values
- If the results are inconsistent with clinical evidence, additional testing is suggested to confirm the result. Negative results do not rule out the diagnosis of CTD. ANA IFA or ANA Blot remains the optimal testing method.
- Samples should be taken after 8 hrs of last dose, from patients receiving therapy with high dose of Biotin.
- In some cases, interference due to antibodies against analyte specific antibodies, ruthenium, streptavidin etc can be seen.

References :
1. Lecaa B , Jd C , Dvd E , et al. Antinuclear antibodies (ANA) as a criterion for classification and diagnosis of systemic autoimmunediseases[J].ransl Autoimmun. 2022. Jan 19;5:100145.
2. Agmon-Levin N, Damoiseaux J, Kallenberg C, et al. International recommendations for the assessment of autoantibodies to cellular antigens referred to as anti-nuclear antibodies.
Ann Rheum Dis. 2014;73(1):17-23. doi:10.1136/annrheumdis-2013-203863

Method : Chemiluminescent Microparticle immunoassay (C.M.I.A.)

Please correlate with clinical conditions.

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

Scan QR to verify(valid for 30 days from release time)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
AMYLASE	PHOTOMETRY	71.4	U/L

Bio. Ref. Interval. :-

Adults : 28-100 U/L

Interpretation:
Lipemic Sera (Hypertriglyceridemia) may contain inhibitors, Which falsely depress results. About 20% of patients with Acute Pancreatitis have abnormal lipids. Normal serum amylase may occur in Pancreatitis, Especially relapsing and chronic pancreatitis. Moderate increases may be reported in normal pregnancy.

Clinical Significance:
Causes of high Serum Amylase include Acute Pancreatitis, Pancreatic Pseudocyst, Pancreatic Ascites, Pancreatic Abscess, Neoplasm in or adjacent to Pancreas, Trauma to Pancreas, and common Duct Stones. Nonpancreatic Causes include inflammatory salivary lesions (Eg, Mumps), Perforated Peptic Ulcer, Intestinal Obstruction, Biliary Tract Disease, Peritonitis, Acute Appendicitis, Diabetic Ketoacidosis, and Extrapancreatic Carcinomas. Amylase levels more than 25-fold the upper limit of normal are often found when metastatic tumors produce Ectopic Amylase.

Specifications:
Precision: Intra assay (%CV): 2.82, Inter assay (%CV): 2.49, Sensitivity: 10.9 U/L.

Kit Validation References:
Rauscher, E., et coll., Fresenius Z. Analyt. Chem. 324 (1986) 304-305.

Please correlate with clinical conditions.
Method:- ENZYMATIC COLORIMETRIC TEST

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

Scan QR to verify(valid for 30 days from release time)

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

TEST NAME	TECHNOLOGY	VALUE	UNITS
ANTI CCP (ACCP)	C.M.I.A	< 0.5	U/mL

Reference Range :-

BRI	Interpretation
Negative < 5	Absence of IgG autoantibodies to cyclic citrullinated peptides (CCP)
Positive ≥ 5	Presence of IgG autoantibodies to cyclic citrullinated peptides (CCP)

Clinical Significance :

1. Anti-Cyclic-Citrullinated-Peptide (Anti-CCP) titre is used for diagnosis and monitoring of Rheumatoid Arthritis (RA).
2. RA is one of the most common systemic autoimmune diseases characterised by chronic inflammation of the synovial joints and progressive joint degeneration eventually leading to disability of affected individuals.
3. The diagnosis of RA often relies on clinical manifestations and certain non-specific laboratory tests such as rheumatoid factor (RF) and C-reactive protein (CRP), which may be present in healthy elderly persons or in patients with other autoimmune and infectious diseases.
4. Whereas, Anti-Cyclic-Citrullinated-Peptide (Anti-CCP) Antibodies hold promise for early and more accurate detection of Rheumatoid Arthritis before the disease proceeds into irreversible damage.
5. Interference with pathologic levels of nonspecific IgG can not be excluded.
6. The anti-CCP test results can be false negative in patients with hypergammaglobulinemia. Results from patients suffering from this disorder should not be used for diagnostic purposes.
7. Heterophile antibodies may interfere with the test results.
8. If results are inconsistent with clinical history additional testing is suggested to confirm the results.
9. Some specimens may not dilute linearly because of heterogeneity of autoantibodies with respect to physicochemical properties.
10. HAMA (Human Anti mouse antibodies) may also interfere with the results.
11. For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

References:

- Anti-CCP Reagent Kit Insert
- Feldmann M, Brennan FM, Maini RN. Rheumatoid arthritis.Cell 1996;85:307-3102.
- Landewé RB. The benefits of early treatment in rheumatoid arthritis:confounding by indication, and the issue of timing. Arthritis Rheum 2003;48(1):1-5.

Please correlate with clinical conditions.

Method:- Fully Automated ChemiLuminescent Microparticle Immunoassay (C.M.I.A)

Tests Done : **AAROGYAM TAX SAVER - ADVANCED WITH UTSH,PHOSPHOROUS**

Dr Ranjana Roy
MD(Path)

Dr Shrusty Sonar
MD(Path)

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Processed At :
H. NO. 1-9-645, Vidyanagar,
Adikmet Road, Near SBH,
Hyderabad-500044

MC-5241

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Patient Name	: XXX XXX XXX	**Sample Collected on (SCT)**	: XXX XXX
Referred By	: SELF	**Sample Received on (SRT)**	: 17 Jul 2026 15:03
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: 17 Jul 2026 16:02
		Sample Type | Barcode	: FLUORIDE PLASMA | FW728078

TEST NAME	TECHNOLOGY	VALUE	UNITS
FASTING BLOOD SUGAR(GLUCOSE)	**PHOTOMETRY**	**173.38**	**mg/dL**

Bio. Ref. Interval. :-

As per ADA Guideline: Fasting Plasma Glucose (FPG)	
Normal	70 to 100 mg/dl
Prediabetes	100 mg/dl to 125 mg/dl
Diabetes	126 mg/dl or higher

Note :
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 Glucose in a given specimen may vary due to differences in assay methods, calibration and reagent specificity. For diagnostic purposes results should always be assessed in conjunction with patients medical history, clinical findings and other findings.

Please correlate with clinical conditions.

Method:- GOD-POD METHOD

Dr Amulya MD (Path)

Dr Abdur R MD (Biochem)

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Patient Name : XXX XXX XXX
Referred By : SELF
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : XXX XXX
Sample Received on (SRT) : 17 Jul 2026 15:24
Report Released on (RRT) : 17 Jul 2026 18:09
Sample Type | Barcode : URINE | FQ684424

TEST NAME	METHODOLOGY	VALUE	UNITS	Bio. Ref. Interval.
Complete Urinogram				
Physical Examination				
SPECIFIC GRAVITY	pKa change	1.020	-	1.003-1.030
PH	pH indicator	5.5	-	5-8
Chemical Examination				
URINARY GLUCOSE	GOD-POD	ABSENT	mg/dL	Absent
URINARY BILIRUBIN	Diazo coupling	ABSENT	mg/dL	Absent
URINE KETONE	Nitroprusside	ABSENT	mg/dL	Absent
URINE BLOOD	Peroxidase reaction	ABSENT	-	Absent
URINARY PROTEIN	**PEI**	**Trace (15-30 mg/dl)**	**mg/dL**	**Absent**
UROBILINOGEN	Diazo coupling	Normal	mg/dL	<=0.2
NITRITE	Diazo coupling	ABSENT	-	Absent
Microscopic Examination				
URINARY LEUCOCYTES (PUS CELLS)	Microscopy	ABSENT	cells/HPF	0-5

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

Dr Amulya MD (Path)

Scan QR to verify(valid for 30 days from release time)

Processed At :
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Hyderabad-500044

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Patient Name	: XXX XXX XXX	**Sample Collected on (SCT)**	: XXX XXX
Referred By	: SELF	**Sample Received on (SRT)**	: 17 Jul 2026 15:24
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: 17 Jul 2026 18:09
		Sample Type | Barcode	: URINE | FQ684424

TEST NAME	TECHNOLOGY	VALUE	UNITS
DIABETES SCREEN (URINE)			
URINARY MICROALBUMIN	**PHOTOMETRY**	**112.82**	**µg/mL**
Bio. Ref. Interval. : Adults: Less than 25 µg/ml			
Method : Fully Automated Immuno Turbidometry			
CREATININE - URINE	PHOTOMETRY	145.84	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**	**77.4**	**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.

Dr Amulya MD (Path)

Scan QR to verify(valid for 30 days from release time)

Patient Name	: **XXX XXX XXX**	**Sample Collected on (SCT)**	: **XXX XXX**
Referred By	: **SELF**	**Sample Received on (SRT)**	: **18 Jul 2026 04:54**
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: **18 Jul 2026 20:00**
		Sample Type | Barcode	: **EDTA Whole Blood | FT751577**

TEST NAME	METHODOLOGY	VALUE	UNITS	Bio. Ref. Interval.
HEMOGLOBIN	**SLS-Hemoglobin Method**	**12.5**	**g/dL**	**13.0-17.0**
Hematocrit (PCV)	CPH Detection	40.3	%	40.0-50.0
Total RBC	HF & EI	5.41	X 10^6/µL	4.5-5.5
Mean Corpuscular Volume (MCV)	**Calculated**	**74.5**	**fL**	**83.0-101.0**
Mean Corpuscular Hemoglobin (MCH)	**Calculated**	**23.1**	**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**	**48.5**	**fL**	**39-46**
Red Cell Distribution Width (RDW - CV)	**Calculated**	**19.5**	**%**	**11.6-14**
RED CELL DISTRIBUTION WIDTH INDEX (RDWI)	Calculated	268.5	-	*Refer Note below
MENTZER INDEX	Calculated	13.8	-	*Refer Note below
TOTAL LEUCOCYTE COUNT (WBC)	**HF & FC**	**11.32**	**X 10³ / µL**	**4.0 - 10.0**
DIFFERENTIAL LEUCOCYTE COUNT				
Neutrophils Percentage	Flow Cytometry	68	%	40-80
Lymphocytes Percentage	Flow Cytometry	27.4	%	20-40
Monocytes Percentage	Flow Cytometry	2.1	%	2-10
Eosinophils Percentage	Flow Cytometry	1.2	%	1-6
Basophils Percentage	Flow Cytometry	1	%	0-2
Immature Granulocyte Percentage (IG%)	Flow Cytometry	0.3	%	0-0.5
Nucleated Red Blood Cells %	Flow Cytometry	0.01	%	0.0-5.0
ABSOLUTE LEUCOCYTE COUNT				
Neutrophils - Absolute Count	**Calculated**	**7.7**	**X 10³ / µL**	**2.0-7.0**
Lymphocytes - Absolute Count	**Calculated**	**3.1**	**X 10³ / µL**	**1.0-3.0**
Monocytes - Absolute Count	Calculated	0.24	X 10³ / µL	0.2 - 1.0
Basophils - Absolute Count	**Calculated**	**0.11**	**X 10³ / µL**	**0.02 - 0.1**
Eosinophils - Absolute Count	Calculated	0.14	X 10³ / µL	0.02 - 0.5
Immature Granulocytes (IG)	Calculated	0.03	X 10³ / µL	0-0.3
Nucleated Red Blood Cells	Calculated	0.01	X 10³ / µL	0.0-0.5
PLATELET COUNT	HF & EI	400	X 10³ / µL	150-410
Mean Platelet Volume (MPV)	Calculated	9.6	fL	6.5-12
Platelet Distribution Width (PDW)	Calculated	10.7	fL	9.6-15.2
Platelet to Large Cell Ratio (PLCR)	Calculated	22.4	%	19.7-42.4
Plateletcrit (PCT)	Calculated	0.38	%	0.19-0.39

Remarks : Alert!!! RBCs:Moderate anisocytosis mild poikilocytosis. Predominantly microcytic hypochromic cells with ovalocytes & elliptocytes. Platelets:Appear adequate in smear.

***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 : **ELEMENTS 22 (TOXIC AND NUTRIENTS),HBA PROFILE,HEMOGRAM - 6 PART (DIFF)**

Dr Ranjana Roy
MD(Path)

Dr Dr
XYZMD(Path)

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Processed At :
D-37/1,TTC MIDC,Turbhe, Navi Mumbai - 400703

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Patient Name	: XXX XXX XXX	**Sample Collected on (SCT)**	: XXX XXX
Referred By	: SELF	**Sample Received on (SRT)**	: 18 Jul 2026 04:54
Address	: XXX XXX XXX XXX XXX	**Report Released on (RRT)**	: 18 Jul 2026 20:00
		Sample Type | Barcode	: EDTA Whole Blood | FT751577

TEST NAME	TECHNOLOGY	VALUE	UNITS
HbA1c	**H.P.L.C**	**7.4**	**%**

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**	**166**	**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.

Dr XYZ
MD(Path)

Dr XYZM
D(Path)

Scan QR to verify(valid for 30 days from release time)

Patient Name : **XXX XXX XXX**
Referred By : **SELF**
Address : XXX XXX XXX XXX XXX

Sample Collected on (SCT) : **XXX XXX**
Sample Received on (SRT) : **18 Jul 2026 04:54**
Report Released on (RRT) : **18 Jul 2026 20:00**
Sample Type | Barcode : **EDTA Whole Blood | FT751577**

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval
ARSENIC	ICP-MS	3.98	µg/L	< 5
CADMIUM	ICP-MS	0.77	µg/L	< 1.5
MERCURY	ICP-MS	0.36	µg/L	< 5
LEAD	ICP-MS	49.41	µg/L	< 150
CHROMIUM	ICP-MS	1	µg/L	< 30
BARIUM	ICP-MS	2.88	µg/L	< 30
COBALT	ICP-MS	0.56	µg/L	0.10 - 1.50
CAESIUM	ICP-MS	0.49	µg/L	< 5
THALLIUM	ICP-MS	0.04	µg/L	< 1
URANIUM	ICP-MS	0.04	µg/L	< 1
STRONTIUM	ICP-MS	15.38	µg/L	8 - 38
ANTIMONY	ICP-MS	9.92	µg/L	0.10 - 18
TIN	ICP-MS	0.42	µg/L	< 2
MOLYBDENUM	ICP-MS	1.79	µg/L	0.70 - 4.0
SILVER	ICP-MS	0.58	µg/L	< 4
VANADIUM	ICP-MS	0.56	µg/L	< 0.8
BERYLLIUM	ICP-MS	0.05	µg/L	<0.10
BISMUTH	ICP-MS	0.47	µg/L	0.10 - 0.80
SELENIUM	ICP-MS	138.42	µg/L	60 - 340
ALUMINIUM	ICP-MS	7.18	µg/L	< 30
NICKEL	ICP-MS	4.25	µg/L	< 15
MANGANESE	ICP-MS	12.83	µg/L	7.10 - 20

Please correlate with clinical conditions.

Method :

ICP - MASS SPECTROMETRY
Note:Reference range has been obtained after considering 95% population as cutoff.

Dr XYZ
MD(Path)

Dr XYZM
D(Path)

Scan QR to verify(valid for 30 days from release time)

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*