Thyrocare

Tests you can trust

Name : xxxxxxxxxxxxxxxx

Date : xxxxxxxxxxxxxxxx

Test Asked : Aarogyam 1.8 With Utsh

Report Status: Complete Report

First National Diagnostic Chain to have
100% of its Labs with NABL Accreditation#

98% Reports released within **06 Hours** of sample reaching the lab*

9 out of 10 Doctors Trust that Thyrocare reports are **Accurate & Reliable***

1200+ Tests & Profiles

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Abnormal Values Re-Checked Twice

Reports Verified By Expert MD Pathologists Stationed at Every Lab

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QR code will remain active for 30 days from report release date

Accredited by

NABL From 2005

ISO 9001: 2015 - From 2015

CAP From 2007

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Thyrocare Technologies Limited, D-37/3, TTC MIDC, Turbhe, Navi Mumbai - 400 703 9870666333 wellness@thyrocare.com

First National Diagnostic Chain to have 100% of its Labs with NABL Accreditation#

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Report Availability Summary

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

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

TEST DETAILS	REPORT STATUS
AAROGYAM 1.8 WITH UTSH	Ready
CHLORIDE	Ready
CYSTATIN C	Ready
FRUCTOSAMINE	Ready
HOMOCYSTEINE	Ready
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	Ready
INSULIN - FASTING	Ready
LIPASE	Ready
Lipoprotein (a) [Lp(a)]	Ready
LP-PLA2	Ready
SERUM COPPER	Ready
SERUM ZINC	Ready
SODIUM	Ready
TESTOSTERONE	Ready
ALPHA-1-ANTITRYPSIN (AAT)	Ready
VITAMIN A	Ready
VITAMIN E	Ready
VITAMIN K	Ready
HBA PROFILE	Ready
HEMOGRAM - 6 PART (DIFF)	Ready
LIVER FUNCTION TESTS	Ready

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Report Availability Summary

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

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

TEST DETAILS	REPORT STATUS
ELEMENTS 22 (TOXIC AND NUTRIENTS)	Ready
IRON DEFICIENCY PROFILE	Ready
KIDPRO	Ready
LIPID PROFILE	Ready
VITAMIN D PROFILE	Ready
VITAMIN B COMPLEX PROFILE	Ready
T3-T4-USTSH	Ready
APOLIPROTEIN RATIO	Ready
AMYLASE	Ready
BLOOD KETONE (D3HB)	Ready

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Summary Report

Tests outside reference range

TEST NAME	OBSERVED VALUE	UNITS	Bio. Ref. Interval.
CARDIAC RISK MARKERS			
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	13.7	mg/L	< 3
COMPLETE HEMOGRAM			
MEAN CORP.HEMO.CONC(MCHC)	30.6	g/dL	31.5-34.5
DIABETES			
BLOOD KETONE (D3HB)	5.22	mg/dL	0.21-2.81
IRON DEFICIENCY			
IRON	50.9	µg/dL	65 - 175
LIPID			
HDL / LDL RATIO	0.36	Ratio	> 0.40
HDL CHOLESTEROL - DIRECT	33	mg/dL	40-60
TRIG / HDL RATIO	3.26	Ratio	< 3.12
RENAL			
CALCIUM	8.78	mg/dL	8.8-10.6
THYROID			
TSH - ULTRASENSITIVE	18.1	µIU/mL	0.54-5.30
TOXIC ELEMENTS			
BERYLLIUM	0.05	µg/L	0.10 - 0.80

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 pags.

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN A	LC-MS/MS	422.32	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:

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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX
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TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN E	LC-MS/MS	8067.88	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

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HOME COLLECTION :
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TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN K	LC-MS/MS	0.79	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

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HOME COLLECTION :
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PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
VITAMIN B1/THIAMIN	LC-MS/MS	1.26	ng/mL	0.5-4.0
VITAMIN B2/RIBOFLAVIN	LC-MS/MS	16.01	ng/mL	1.6-68.2
VITAMIN B3/NICOTINIC ACID	LC-MS/MS	1.1	ng/mL	0.3-9.8
VITAMIN B5/PANTOTHENIC	LC-MS/MS	147.2	ng/mL	11-150
VITAMIN B6/P5P	LC-MS/MS	8.55	ng/mL	5 - 50
VITAMIN B7/BIOTIN	LC-MS/MS	0.94	ng/mL	0.2-3
VITAMIN B9/FOLIC ACID	LC-MS/MS	0.96	ng/mL	0.2-20

Please correlate with clinical conditions.

Method :

VITB1 - LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY
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

Sample Collected on (SCT) : Sample collection time
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TEST NAME	TECHNOLOGY	VALUE	UNITS
ALPHA-1-ANTITRYPSIN (AAT)	IMMUNOTURBIDIMETRY	158.9	mg/dL

Bio. Ref. Interval. :-

90 - 200 mg/dL

Clinical Significance ;
Alpha-1-antitrypsin (AAT) is a serine protease inhibitor and the third most abundant protein in circulation. AAT levels can increase 3 to 5 folds in states of systemic inflammation or infection. Increased levels are also seen in Covid-19 patients. Usually, the increase in AAT is directly proportional to the increase in IL6, supporting an anti inflammatory function. It is also considered that patients with Alpha-1-antitrypsin deficiency (AATD) might be at increased risk of SARS-CoV-2 infection and development of severe COVID-19.

Alpha-1 antitrypsin (AAT) deficiency can cause various medical complications of the lungs, liver, and skin, including COPD, emphysema, chronic bronchitis, cirrhosis of the liver and other side effects of the excess enzyme.

Specifications;
Precision (%CV) : Intra-assay %CV: 1.4 %, Inter-assay %CV: 1.36%

Kit Validation reference ;
1.Janciauskiene SM, Bals R, Koczulla R, et al. The discovery of Alpha1-antitrypsin and its role in health and disease. Respir Med, 2011, 105(8) : 1129-1139
2.Sun Z, Yang P. Role of imbalance between neutrophil elastase and alpha1-antitrypsin in cancer development and progression. Lancet Oncol, 2004, 5(3) : 182-190

Please correlate with clinical conditions.
Method:- Polyethylene glycol(PEG)-enhanced immunoturbidimetric

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
HOMOCYSTEINE	PHOTOMETRY	8.05	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)

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

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HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
CYSTATIN C	IMMUNOTURBIDIMETRY	0.96	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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
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Labcode :
Barcode :

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PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
APOLIPOPROTEIN - A1 (APO-A1)	IMMUNOTURBIDIMETRY	99	mg/dL

Bio. Ref. Interval. :
Male : 86 - 152
Female : 94 - 162
Method : FULLY AUTOMATED RATE IMMUNOTURBIDIMETRY – BECKMAN COULTER

APOLIPOPROTEIN - B (APO-B)	IMMUNOTURBIDIMETRY	79	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	0.8	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.

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PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN B-12	E.C.L.I.A	456	pg/mL

Bio. Ref. Interval. :
Normal: 197-771 pg/ml

Clinical significance :
Vitamin B12 or cyanocobalamin, is a complex corrinoid compound found exclusively from animal dietary sources, such as meat, eggs and milk. It is critical in normal DNA synthesis, which in turn affects erythrocyte maturation and in the formation of myelin sheath. Vitamin-B12 is used to find out neurological abnormalities and impaired DNA synthesis associated with macrocytic anemias. For diagnostic purpose, results should always be assessed in conjunction with the patients medical history, clinical examination and other findings.

Specifications: Intra assay (%CV):2.6%, Inter assay (%CV):2.3 %

Kit Validation Reference : Thomas L.Clinical laborator Diagnostics : Use and Assessment of Clinical laboratory Results 1st Edition,TH Books-Verl-Ges,1998:424-431

Method : Fully Automated Electrochemiluminescence Compitive Immunoassay

Please correlate with clinical conditions.

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TEST NAME	TECHNOLOGY	VALUE	UNITS
INSULIN - FASTING	C.L.I.A	5.11	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.

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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TEST NAME	TECHNOLOGY	VALUE	UNITS
BLOOD KETONE (D3HB)	**PHOTOMETRY**	**5.22**	**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)

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

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TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
FRUCTOSAMINE	PHOTOMETRY	260.3	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)

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
Lipoprotein (a) [Lp(a)]	IMMUNOTURBIDIMETRY	12.5	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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
LP-PLA2	PHOTOMETRY	134	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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
SERUM COPPER	PHOTOMETRY	129.18	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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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HOME COLLECTION :
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TEST NAME	TECHNOLOGY	VALUE	UNITS
SERUM ZINC	PHOTOMETRY	104.09	µg/dL

Bio. Ref. Interval. :-

52 - 286

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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
TESTOSTERONE	E.C.L.I.A	542	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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	**IMMUNOTURBIDIMETRY**	**13.7**	**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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
AMYLASE	PHOTOMETRY	28	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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
LIPASE	PHOTOMETRY	19.2	U/L

Bio. Ref. Interval. :-

Adults : 5.6 - 51.3 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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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PATIENTID : XXXXXXXXXXXXXXXX

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TOTAL CHOLESTEROL	PHOTOMETRY	137	mg/dL	< 200
HDL CHOLESTEROL - DIRECT	**PHOTOMETRY**	**33**	**mg/dL**	**40-60**
HDL / LDL RATIO	**CALCULATED**	**0.36**	**Ratio**	**> 0.40**
LDL CHOLESTEROL - DIRECT	PHOTOMETRY	92	mg/dL	< 100
TRIG / HDL RATIO	**CALCULATED**	**3.26**	**Ratio**	**< 3.12**
TRIGLYCERIDES	PHOTOMETRY	108	mg/dL	< 150
TC/ HDL CHOLESTEROL RATIO	CALCULATED	4.2	Ratio	3 - 5
LDL / HDL RATIO	CALCULATED	2.8	Ratio	1.5-3.5
NON-HDL CHOLESTEROL	CALCULATED	104.1	mg/dL	< 160
VLDL CHOLESTEROL	CALCULATED	21.56	mg/dL	5 - 40

Please correlate with clinical conditions.

Method :

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

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labode :
Barcode :

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HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
ALKALINE PHOSPHATASE	PHOTOMETRY	79.3	U/L	45-129
BILIRUBIN - TOTAL	PHOTOMETRY	0.72	mg/dL	0.3-1.2
BILIRUBIN -DIRECT	PHOTOMETRY	0.15	mg/dL	< 0.3
BILIRUBIN (INDIRECT)	CALCULATED	0.57	mg/dL	0-0.9
GAMMA GLUTAMYL TRANSFERASE (GGT)	PHOTOMETRY	14.3	U/L	< 55
SGOT / SGPT RATIO	CALCULATED	1.2	Ratio	< 2
ASPARTATE AMINOTRANSFERASE (SGOT)	PHOTOMETRY	20.2	U/L	< 35
ALANINE TRANSAMINASE (SGPT)	PHOTOMETRY	16.8	U/L	< 45
PROTEIN - TOTAL	PHOTOMETRY	7.29	gm/dL	5.7-8.2
ALBUMIN - SERUM	PHOTOMETRY	3.97	gm/dL	3.2-4.8
SERUM GLOBULIN	CALCULATED	3.32	gm/dL	2.5-3.4
SERUM ALB/GLOBULIN RATIO	CALCULATED	1.2	Ratio	0.9 - 2

Please correlate with clinical conditions.

Method :

ALKP - Modified IFCC method
BILT - Vanadate Oxidation
BILD - Vanadate Oxidation
BILI - Derived from serum Total and Direct Bilirubin values
GGT - Modified IFCC method
OT/PT - Derived from SGOT and SGPT values.
SGOT - IFCC* Without Pyridoxal Phosphate Activation
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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX

REF. BY : XXXXXXXXXXXXXXXX

TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
CHLORIDE	I.S.E - INDIRECT	100.2	mmol/L

Bio. Ref. Interval. :
ADULTS: 98-107 MMOL/L

Clinical Significance :
An increased level of blood chloride (called hyperchloremia) usually indicates dehydration, but can also occur with other problems that cause high blood sodium, such as Cushing syndrome or kidney disease. Hyperchloremia also occurs when too much base is lost from the body (producing metabolic acidosis) or when a person hyperventilates (causing respiratory alkalosis). A decreased level of blood chloride (called hypochloremia) occurs with any disorder that causes low blood sodium. Hypochloremia also occurs with congestive heart failure, prolonged vomiting or gastric suction, Addison disease, emphysema or other chronic lung diseases (causing respiratory acidosis), and with loss of acid from the body (called metabolic alkalosis).

Method : ION SELECTIVE ELECTRODE - INDIRECT

Please correlate with clinical conditions.

Sample Collected on (SCT) : Sample collection time

Sample Received on (SRT) : Sample receiving time at Lab

Report Released on (RRT) : Report release time

Sample Type : SERUM

Labcode :

Barcode :

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REF. BY : XXXXXXXXXXXXXXXX

TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
SODIUM	I.S.E - INDIRECT	138.8	mmol/L

Bio. Ref. Interval. :
ADULTS: 136-145 MMOL/L

Method : ION SELECTIVE ELECTRODE - INDIRECT

Please correlate with clinical conditions.

Sample Collected on (SCT) : Sample collection time

Sample Received on (SRT) : Sample receiving time at Lab

Report Released on (RRT) : Report release time

Sample Type : SERUM

Labcode :

Barcode :

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PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
BLOOD UREA NITROGEN (BUN)	PHOTOMETRY	9.72	mg/dL	7.94 - 20.07
UREA (CALCULATED)	CALCULATED	20.8	mg/dL	Adult : 17-43
CALCIUM	**PHOTOMETRY**	**8.78**	**mg/dL**	**8.8-10.6**
URIC ACID	PHOTOMETRY	6.76	mg/dL	4.2 - 7.3
CREATININE - SERUM	PHOTOMETRY	0.87	mg/dL	0.72-1.18
UREA / SR.CREATININE RATIO	CALCULATED	23.91	Ratio	< 52
BUN / SR.CREATININE RATIO	CALCULATED	11.17	Ratio	9:1-23:1
UNSAT.IRON-BINDING CAPACITY(UIBC)	PHOTOMETRY	238.8	µg/dL	162 - 368
IRON	**PHOTOMETRY**	**50.9**	**µg/dL**	**65 - 175**
TOTAL IRON BINDING CAPACITY (TIBC)	PHOTOMETRY	289.7	µg/dL	225-535
% TRANSFERRIN SATURATION	CALCULATED	17.57	%	13 - 45

Please correlate with clinical conditions.

Method :

BUN - Kinetic UV Assay.
UREAC - Derived from BUN Value.
CALC - Arsenazo III Method, End Point.
URIC - Uricase / Peroxidase Method
SCRE - Creatinine Enzymatic Method
UR/CR - Derived from UREA and Sr.Creatinine values.
B/CR - Derived from serum Bun and Creatinine values
UI_BC - SPECTROPHOTOMETRIC ASSAY
IRON - Ferrozine method without deproteinization
TIBC - Spectrophotometric Assay
%TSA - Derived from IRON and TIBC values

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TOTAL TRIIODOTHYRONINE (T3)	E.C.L.I.A	125	ng/dL	80-200
TOTAL THYROXINE (T4)	E.C.L.I.A	8.9	µg/dL	4.8-12.7
TSH - ULTRASENSITIVE	**E.C.L.I.A**	**18.1**	**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.

Sample Collected on (SCT) : Sample collection time
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Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

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HOME COLLECTION :
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TEST NAME	TECHNOLOGY	VALUE	UNITS
EST. GLOMERULAR FILTRATION RATE (eGFR)	CALCULATED	115	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

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

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : SERUM
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
VITAMIN D2	LC-MS/MS	1.47	ng/mL
Method : LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY			
VITAMIN D3	LC-MS/MS	41.3	ng/mL
Method : LIQUID CHROMATOGRAPHY TANDEM MASS SPECTROMETRY			
VITAMIN D TOTAL	CALCULATED	42.77	ng/mL

Bio. Ref. Interval. :
DEFICIENCY : <20 NG/ML
INSUFFICIENCY : 20-30 NG/ML
SUFFICIENCY : 30-100 NG/ML
TOXICITY : >100 NG/ML
Method : Derived from VD2 and VD3 values

Please correlate with clinical conditions.

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Sample Type : SERUM
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HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
ARSENIC	ICP-MS	0.93	µg/L	< 5
CADMIUM	ICP-MS	0.73	µg/L	< 1.5
MERCURY	ICP-MS	0.5	µg/L	< 5
LEAD	ICP-MS	10.34	µg/L	< 150
CHROMIUM	ICP-MS	6.73	µg/L	< 30
BARIUM	ICP-MS	2.1	µg/L	< 30
COBALT	ICP-MS	0.75	µg/L	0.10 - 1.50
CAESIUM	ICP-MS	3.2	µg/L	< 5
THALLIUM	ICP-MS	0.07	µg/L	< 1
URANIUM	ICP-MS	0.04	µg/L	< 1
STRONTIUM	ICP-MS	18.97	µg/L	8 - 38
ANTIMONY	ICP-MS	10.35	µg/L	0.10 - 18
TIN	ICP-MS	0.43	µg/L	< 2
MOLYBDENUM	ICP-MS	0.8	µg/L	0.70 - 4.0
SILVER	ICP-MS	0.3	µg/L	< 4
VANADIUM	ICP-MS	0.57	µg/L	< 0.8
BERYLLIUM	**ICP-MS**	**0.05**	**µg/L**	**0.10 - 0.80**
BISMUTH	ICP-MS	0.53	µg/L	0.10 - 0.80
SELENIUM	ICP-MS	176.04	µg/L	60 - 340
ALUMINIUM	ICP-MS	4.41	µg/L	< 30
NICKEL	ICP-MS	1.26	µg/L	< 15
MANGANESE	ICP-MS	12.9	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.

Sample Collected on (SCT) : Sample collection time
Sample Received on (SRT) : Sample receiving time at Lab
Report Released on (RRT) : Report release time
Sample Type : EDTA Whole Blood
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID : XXXXXXXXXXXXXXXX

TEST NAME	TECHNOLOGY	VALUE	UNITS
HbA1c	H.P.L.C	5.1	%

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	100	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.

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Doctor 1 Sign Doctor 2 Sign

PROCESSED AT :

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First National Diagnostic Chain to have 100% of its Labs with NABL Accreditation#

NAME : XXXXXXXXXXXXXXXX
REF. BY : XXXXXXXXXXXXXXXX
TEST ASKED : AAROGYAM 1.8 WITH UTSH

HOME COLLECTION :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENTID :

TEST NAME	METHODOLOGY	VALUE	UNITS	Bio. Ref. Interval.
HEMOGLOBIN	SLS-Hemoglobin Method	14.7	g/dL	13.0-17.0
Hematocrit (PCV)	CPH Detection	48	%	40.0-50.0
Total RBC	HF & EI	5.29	X 10^6/µL	4.5-5.5
Mean Corpuscular Volume (MCV)	Calculated	90.7	fL	83.0-101.0
Mean Corpuscular Hemoglobin (MCH)	Calculated	27.8	pg	27.0-32.0
Mean Corp.Hemo. Conc (MCHC)	**Calculated**	**30.6**	**g/dL**	**31.5-34.5**
Red Cell Distribution Width - SD (RDW-SD)	Calculated	43.9	fL	39-46
Red Cell Distribution Width (RDW - CV)	Calculated	13.3	%	11.6-14
RED CELL DISTRIBUTION WIDTH INDEX (RDWI)	Calculated	228	-	*Refer Note below
MENTZER INDEX	Calculated	17.1	-	*Refer Note below
TOTAL LEUCOCYTE COUNT (WBC)	HF & FC	5.85	X 10^3 / µL	4.0 - 10.0
DIFFERENTIAL LEUCOCYTE COUNT				
Neutrophils Percentage	Flow Cytometry	60.9	%	40-80
Lymphocytes Percentage	Flow Cytometry	28.2	%	20-40
Monocytes Percentage	Flow Cytometry	5.8	%	2-10
Eosinophils Percentage	Flow Cytometry	4.3	%	1-6
Basophils Percentage	Flow Cytometry	0.5	%	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	3.56	X 10^3 / µL	2.0-7.0
Lymphocytes - Absolute Count	Calculated	1.65	X 10^3 / µL	1.0-3.0
Monocytes - Absolute Count	Calculated	0.34	X 10^3 / µL	0.2 - 1.0
Basophils - Absolute Count	Calculated	0.03	X 10^3 / µL	0.02 - 0.1
Eosinophils - Absolute Count	Calculated	0.25	X 10^3 / µL	0.02 - 0.5
Immature Granulocytes (IG)	Calculated	0.02	X 10^3 / µL	0-0.3
Nucleated Red Blood Cells	Calculated	0.01	X 10^3 / µL	0.0-0.5
PLATELET COUNT	HF & EI	298	X 10^3 / µL	150-410
Mean Platelet Volume (MPV)	Calculated	11.5	fL	8.5-12
Platelet Distribution Width (PDW)	Calculated	13.5	fL	9.6-15.2
Platelet to Large Cell Ratio (PLCR)	Calculated	36.7	%	19.7-42.4
Plateletcrit (PCT)	Calculated	0.34	%	0.19-0.39

Remarks : Alert!!! Predominantly normocytic normochromic with ovalocytes. 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 (6 Part Differential SYSMEX XN-1000)
(Reference : *FC- flowcytometry, *HF- hydrodynamic focussing, *EI- Electric Impedence, *Hb- hemoglobin, *CPH- Cumulative pulse height**)**

~~ End of report ~~

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Sample Type : EDTA Whole Blood
Labcode :
Barcode :

Doctor 1 Sign Doctor 2 Sign

Scan QR code to verify authenticity of reported results; active 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 **022-309 0000**

*T&C Apply, #As on 5th December 2024, *As per a survey on doctors' perception of laboratory diagnostics (IJARIIT,2023)*