Clinova
PATH LABS PVT. LTD.

LABORATORY TEST REPORT

Patient Name **Mr AVTAR SINGH**
Age : 54 Year(s) Gender : Male
Sample ID : 20534681
Sample Type : WB EDTA
Patient ID : 2126954
Ref. Doctor : NA
Ref. Customer : NA

Lab Code : CPL-HR-221
Sample Collection Date : 2024-06-09 00:00
Registration Date : 2024-06-09 06:10
Approved Date : 2024-06-09 08:38

HEMATOLOGY

Test Description	Result	Units	Biological Reference Ranges
COMPLETE BLOOD PICTURE			
Hemoglobin *(Method: SLS/Photometric)*	**8.1**	gms%	13.0-17.0
Erythrocyte Count (RBC Count) *(Method: Hydrodynamically focused DC detection method)*	**3.3**	mil/cumm	4.5-5.5
PCV-Packed Cell Volume (Hematocrit) *(Method: RBC pulse height detection method)*	**27.0**	%	40-50
Platelet Count *(Method: Hydrodynamically focused DC detection method/ Microscopy)*	2.08	lakh/Cumm	1.50-4.10
Erythrocyte Indices *(Method: Calculated/Automated 5 Part Coulter)*			
Mean Corpuscular Volume(MCV) *(Method: Calculated)*	**79.7**	FL	83-101
Mean Corpuscular Hemoglobin(MCH) *(Method: Calculated)*	**23.8**	pg	27-32
Mean Corpuscular Hemoglobin Concentration(MCHC) *(Method: Calculated)*	**29.9**	gm%	31.5-34.5
Red blood cell Distribution Width(RDW-CV) *(Method: Calculated)*	**14.3**	%	11.6-14.0
Total Leukocyte & Differential Count *(Method: Flowcytometry method/ Microscopy)*			
Total Leucocyte Count(WBC) *(Method: Cell Counter/Miccroscopy)*	5380	cells/Cumm	4000-10000
Neutrophils *(Method: Cell Counter/Miccroscopy)*	52	%	40-80
Lymphocytes *(Method: Cell Counter/Miccroscopy)*	40	%	20-40
Eosinophils *(Method: Cell Counter/Miccroscopy)*	02	%	01-06
Monocytes *(Method: Cell Counter/Miccroscopy)*	06	%	02-10
Basophils *(Method: Cell Counter/Miccroscopy)*	**00**	%	00-01
MICROSCOPIC BLOOD PICTURE			
RBC Morphology	Microcytic Hypochromic Cells		
WBC Morphology	Normal in Morphology		
Platelet Morphology	Adequate		
Hemoparasites	Not found		
Impression	**Microcytic Hypochromic Anemia**		
Advise	Correlate Clinically		

--End of Report--

ilac-MRA MC-4662

Dr. Ashutosh Sharma
Consultant Pathologist(DMC Regno:26893)

This is an electronically authenticated report. Report printed date : 09/06/2024 10:59?
Please scan the above QR code to check the authenticity of laboratory report.
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Processed at : Clinova Pathlabs Pvt. Ltd., Phase-2, New Delhi-110020

Note :

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PATH LABS PVT. LTD.

LABORATORY TEST REPORT

Patient Name **Mr AVTAR SINGH**
Age : 54 Year(s) Gender : Male
Sample ID : 20534680
Sample Type : Serum
Patient ID : 2126954
Ref. Doctor : NA
Ref. Customer : NA

Lab Code : CPL-HR-221
Sample Collection Date : 2024-06-09 00:00
Registration Date : 2024-06-09 06:12
Approved Date : 2024-06-09 11:01

CLINICAL BIOCHEMISTRY

Test Description	Result	Units	Biological Reference Ranges
Kidney Function Mini Profile			
Creatinine, Serum *(Method: Jaffe Kinetic)*	**5.9**	mg/dL	0.7 - 1.4
Urea, Serum *(Method: Urease and Glutamate Dehydrogenase)*	**135.6**	mg/dL	8.0-45.0
Blood Urea Nitrogen (BUN) *(Method: Urease)*	**63.4**	mg/dL	7 - 18
BUN/Creatinine Ratio *(Method: Calculation)*	10.8	Ratio	6-22
Sodium, Serum *(Method: ISE Direct)*	**131**	mmol/L	135 - 145
Potassium, Serum *(Method: ISE Direct)*	**5.6**	mmol/L	3.8 - 5.2
Chloride, Serum *(Method: ISE Direct)*	97	mmol/L	94-108
Uric Acid, Serum *(Method: Uricase / Peroxidase)*	4.8	mg/dL	3.4 - 7.0

Uric acid use for diagnosis and treatment of renal failure cases. Monitoring patients receiving cytotoxic drugs and a variety of other disorders, including gout, leukemia, psoriasis, starvation and other wasting conditions.

Increased levels may cause:

Increased purine synthesis
Inherited metabolic disorder
Excess dietary purine intake
Increased nucleic acid turnover
Malignancy
Cytotoxic drugs,
Chronic renal failure
Increased renal reabsorption

Decreased levels may cause

Secondary to severe hepatocellular disease
Reduced purine synthesis
Defective renal tubular reabsorption

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CLINICAL BIOCHEMISTRY

Test Description	Result	Units	Biological Reference Ranges
Liver Function Profile			
Bilirubin Total *(Method: Diazo Method)*	0.4	mg/dL	0 - 1.0
Bilirubin Direct *(Method: Diazo Method)*	0.2	mg/dL	0 - 0.3
Bilirubin Indirect *(Method: Calculation)*	0.2	mg/dL	< 1.0
Alkaline Phosphatase (ALP) *(Method: PNPP, AMP Buffer)*	**156**	U/L	50-136
Alanine Transaminase (ALT/SGPT) *(Method: UV without pyridoxal -5-phosphate)*	15	U/L	5-40
Aspartate Aminotransferase (AST/SGOT) *(Method: IFCC Without Pyridoxal Phosphate)*	9.93	U/L	5-40
Gamma Glutamyl Transferase (GGT) *(Method: Gamma-glutamyl-carboxy-nitroanilide)*	21	U/L	8 - 61
Protein Total *(Method: Biuret)*	6.7	g/dL	6.6 - 8.7
Albumin, Serum *(Method: Bromocresol Green (BCG))*	4.2	g/dL	3.5-5.2
Globulin *(Method: Calculation)*	2.5	g/dL	2.5-3.5
Albumin / Globulin Ratio *(Method: Calculation)*	1.7	Ratio	1.0-2.1

Interpretation:

Liver function test is screening for liver damage, especially if someone has a condition or is taking a drug that may affect the liver. It is used to help diagnose liver disease if a person has signs and symptoms that indicate possible liver dysfunction. If a person has a known condition or liver disease, testing may be performed at intervals to monitor the health of the liver and to evaluate the effectiveness of any treatments. Abnormal tests on a liver panel may prompt a repeat analysis of one or more tests, or of the whole panel, to see if the elevations or decreases persist and may indicate the need for additional testing to determine the cause of the liver dysfunction. Hepatic function panel results are not diagnostic of a specific condition; they indicate that there may be a problem with the liver. In a person who does not have symptoms or identifiable risk factors, abnormal liver test results may indicate a temporary liver injury or reflect something that is happening elsewhere in the body-such as in the skeletal muscles, pancreas, or heart. It may also indicate early liver disease and the need for further testing and periodic monitoring. Results of liver panels are usually evaluated together. Several sets of results from tests performed over a few days or weeks are often assessed together to determine if a pattern is present. Each person will have a unique set of test results that will typically change over time. A healthcare practitioner evaluates the combination of liver test results to gain clues about the underlying condition. Often, further testing is necessary to determine what is causing the liver damage or disease.

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

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Dr. Ashutosh Sharma
Consultant Pathologist(DMC Regno:26893)

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Processed at : Clinova Pathlabs, A-26, Second Floor, Naraina Industrial Area, Phase-2, New Delhi-110028

तारीख व हस्ताक्षर DATE & INITIALS	TREATMENT AND INVESTIGATION ORDERED

4 JUN 2024
PGIMER, CHANDIGARH

SUPPLY FOLLOWING DRUGS OR EQUIVALENT GENERIC DRUGS

CKD - 5D
BP 133/80
P - 72
MHD - 2/wk
DV - 2yr
AVF ⊕ / Thrill ⊕

CR N
Name
Age/
Father
Address
Depar
Unit/
Room
Amoun
Unit

Doing fine

CBC - 8.1 / 5280 / 2.08/9k
HbA1c - 5.4%
Ca - 8.6, Vit D - 22.4 ↓, PO4 - 16.9
Iron - 45, TS - 12.7
U/c - 135/5.9, N/K - 131/5.6
TP/Alb → 6.7/4.2

केवल जाँच के लिए / FOR INVESTIGATIONS ONLY
ऑनलाइन लैब रिपोर्ट वेबसाइट pgimer.edu.in/ors.gov.in पर उपलब्ध है।
Lab test reports are available on website pgimer.edu.in/ors.gov.in

2D Echo
DCMP - 35%
mod MR

DDR updated on 27/06/24

U/O 200 mL

CBC / SEKR
ECR / Ca / PO4
Vit D / iPTH
HbsAg / Anti HCV

Adv
O SR0
O mito - 3/wk
O T. Warize 10g hs
O T. Labetalol 100g TDS
O T. Minipress XL 5mg hs
O T. Arkamine 0.1g TDS
O T. Absocure 800g TDS c meals
O T. Calbade 667g TDS c meals
O Inj. Transfer 10k weekly once
O T. Orofol OD
O C. CALDF D3 60k weekly once

Dr. Rajesh