NOSTIC REPORT

agilus diagnostics

PATIENT NAME : JILANI ANSARI	REF. DOCTOR : DR. MO DCDC	
	ACCESSION NO : 0707XG000210	AGE/SEX : 32 Years Male
	PATIENT ID : JILAM040303707	DRAWN : 04/07/2024 09:31:56
	CLIENT PATIENT ID :	RECEIVED : 04/07/2024 09:34:29
	ABHA NO :	REPORTED : 04/07/2024 19:23:13

Test Report Status Final	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	9.7 Low	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	3.96 Low	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT	4.70	4.0 - 10.0	thou/µL
PLATELET COUNT	149 Low	150 - 410	thou/µL

RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	30.1 Low	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV)	76.0 Low	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	24.4 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.1	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	15.2 High	11.6 - 14.0	%
MENTZER INDEX	19.2		
MEAN PLATELET VOLUME (MPV)	9.6	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT			
NEUTROPHILS	48	40 - 80	%
LYMPHOCYTES	46 High	20 - 40	%
MONOCYTES	04	2 - 10	%
EOSINOPHILS	02	1 - 6	%
BASOPHILS	0	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	2.26	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	2.16	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	0.19 Low	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.09	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.0		

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

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ULR No.775000008259223-0707

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

GNOSTIC REPORT

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HAEMATOLOGY

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD			
E.S.R	**70 High**	0 - 14	mm at 1 hr

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-**TEST DESCRIPTION :-**
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR(**>100 mm/hour**) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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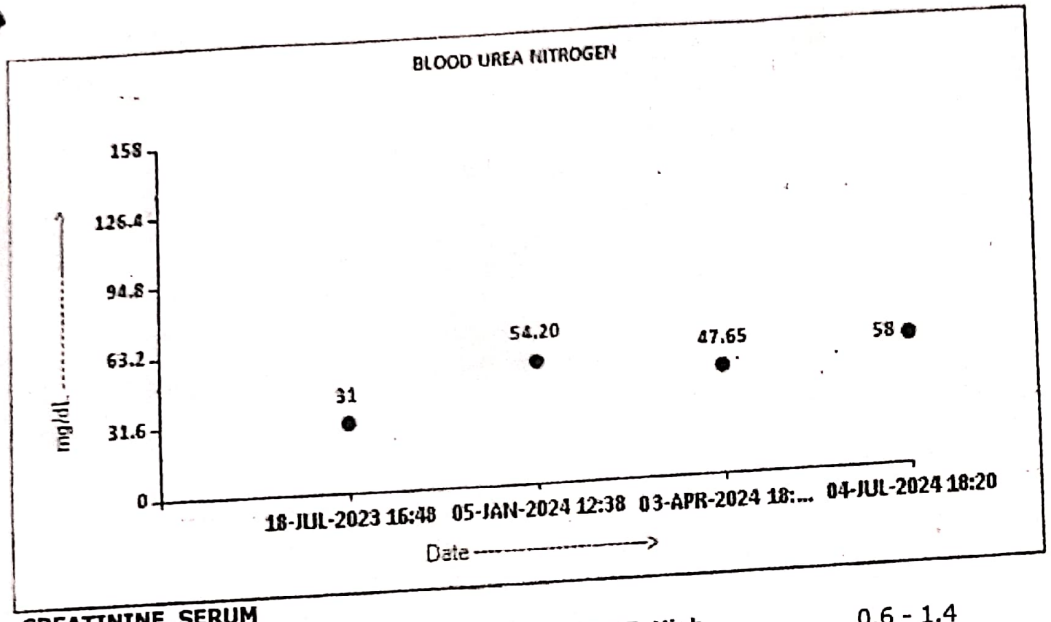
BIOCHEMISTRY

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM			mg/dL
BLOOD UREA NITROGEN	**58 High**	6 - 22	



CREATININE, SERUM			mg/dL
CREATININE	**12.27 High**	0.6 - 1.4	

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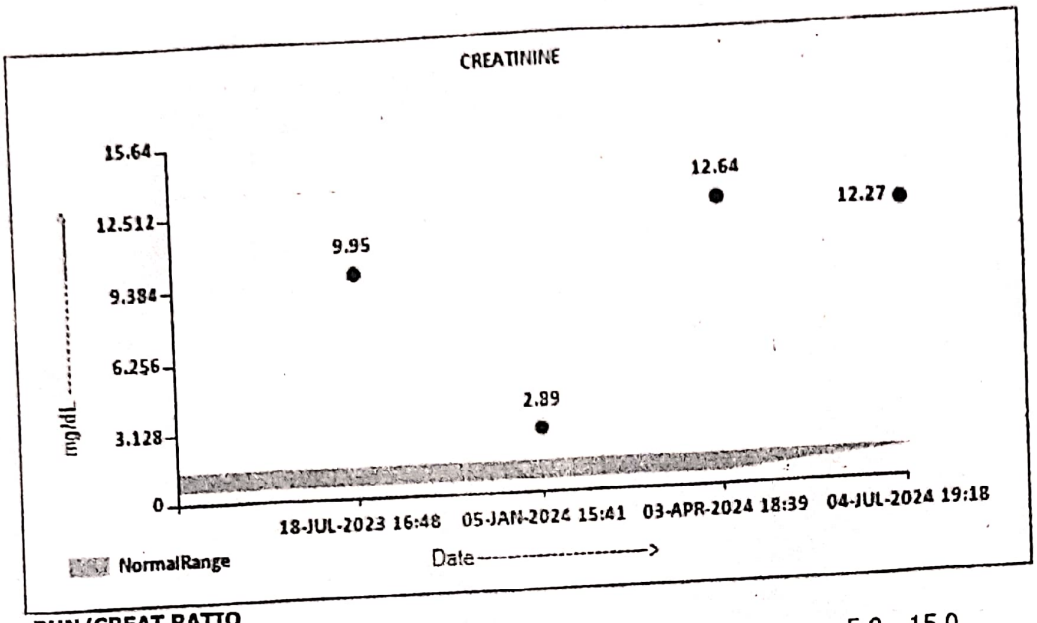

BUN/CREAT RATIO			
BUN/CREAT RATIO	**4.73 Low**	5.0 - 15.0	
CALCIUM, SERUM			
CALCIUM	**7.7 Low**	8.4 - 10.4	mg/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**132.3 Low**	137 - 145	mmol/L
POTASSIUM, SERUM	**5.77 High**	3.6 - 5.0	mmol/L
CHLORIDE, SERUM	**107.6 High**	98 - 107	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride

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ULR No.775000008259223-0707

MC-5746

PATIENT NAME : JILANI ANSARI | **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : CR00000044 - AGILUS AGILUS PATHLABS REACH LIMITED OPD PATIENTS SADAR HOSPITAL, BOKORO, SECTOR - 1, BOKORO STEEL CITY, BOKARO 827001 7260813496	ACCESSION NO : **0031XG003934** PATIENT ID : JILAM05079231 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 32 Years Male DRAWN : 04/07/2024 09:07:00 RECEIVED : 05/07/2024 13:20:09 REPORTED : 05/07/2024 15:02:35

CLINICAL INFORMATION :

0707XG000210

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
URIC ACID, SERUM			
URIC ACID METHOD : URICASE	7.9 High	3.5 - 7.2	mg/dL
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.60	0.2 - 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZONIUM SALT	0.17	0.0 - 0.5	mg/dL
BILIRUBIN, INDIRECT METHOD : DIAZO REACTION	0.43	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : CALCULATED	7.4	6.0 - 8.30	g/dL
ALBUMIN METHOD : BIURET	4.4	3.5 - 5.2	g/dL
GLOBULIN METHOD : COLORIMETRIC (BROMCRESOL GREEN)	3.0	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.5	1 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	7	5 - 34	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	8	0 - 55	U/L
ALKALINE PHOSPHATASE METHOD : PARA-NITROPHENYL PHOSPHATE	139	40 - 150	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD	11	11 - 59	U/L
LACTATE DEHYDROGENASE METHOD : IFCC LACTATE TO PYRUVATE	154	125 - 220	U/L

Interpretation(s)
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis

A Chatterjee

Dr.Anwesha Chatterjee
Pathologist

chaitali.

Dr. Chaitali Ray, PHD
Biochemist

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PERFORMED AT :
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CIN - U74899PB1995PLC045956

ULR No.31000005053165-0031

GNOSTIC REPORT

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PATIENT NAME : JILANI ANSARI	**REF. DOCTOR : DR. MO DCDC**	
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	CLIENT PATIENT ID:	RECEIVED : 04/07/2024 09:34:29
	ABHA NO :	REPORTED : 04/07/2024 19:23:11

Test Report Status **Final**	Results	Biological Reference Interval	Units
EIA - INFECTIOUS SECTION			
HEPATITIS B SURFACE ANTIGEN, SERUM			
HEPATITIS B SURFACE ANTIGEN	NON REACTIVE	NON REACTIVE	
HEPATITIS C ANTIBODIES, SERUM			
HEPATITIS C ANTIBODIES	NON REACTIVE	NON REACTIVE	

Interpretation(s)
HEPATITIS B SURFACE ANTIGEN, SERUM-**Hepatitis B** is caused by infection with HBV, a enveloped DNA agent that is classified as hepadnavirus. This test detects the presence of viral surface antigen i.e HBsAg also known as "Australia antigen" in serum sample and is indicative of HBV infection, either acute or chronic.
Test Utility: HBsAg is the first serologic marker appearing in the serum 6-16 weeks following hepatitis B viral infection. In typical HBV infection, HBsAg will be detected 2-4 weeks before the liver enzyme levels (ALT) become abnormal and 3-5 weeks before patient develops jaundice. In acute cases HBsAg usually disappears 1-2 months after the onset of symptoms. Persistence of HBsAg for more than 6 months indicates development of either a chronic carrier state or chronic liver disease.The presence of HBsAg is frequently associated with infectivity. HBsAg when accompanied by Hepatitis Be antigen and/or hepatitis B viral DNA almost always indicates infectivity.
Limitations: For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute or chronic infection. If the antibody results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.HBsAg detection will only indicate the presence of surface antigens in the serum and should not be used as the sole criteria for diagnosis, staging or monitoring of HBV infection. This test may be negative during "window period" i.e. after disappearance of anti-HBsAg antibody.The current assay being a highly sensitive test may yield a small percentage of false positive reports. Hence all HBsAg positive specimens should be confirmed with an assay based upon Neutralisation of Human anti Hepatitis B Surface antibody.
HEPATITIS C ANTIBODIES, SERUM-**Hepatitis C Virus (HCV)** is a blood borne flavivirus. It is one of the most important causes of post-blood transfusion as well as community acquired non-A non-B hepatitis and chronic liver failure. Although the majority of infected individuals may be asymptomatic, HCV infection may develop into chronic hepatitis, cirrhosis and/or increased risk of hepatocellular carcinoma.
Notes & Limitations: HCV antibody is typically not detected until approximately 14 weeks after infection (or 5 weeks after appearance of the first biochemical marker of illness) and is almost always detectable by the late convalescent stage of infection. A negative result may also be observed due to loss of HCV antigen, years following resolution of infection. Infants born to hepatitis C infected mothers may have delayed seroconversion to anti-HCV. Hence a negative result should be evaluated cautiously with respect to clinical findings. It is to be noted that absence of HCV antibodies after 14 weeks of exposure is strong evidence against HCV infection.Presence of HCV antibodies does not imply an active Hepatitis C infection but is indicative of both past and/or recent infection .It has been reported that as many as 90% of individuals receiving intravenous commercial immunoglobulin test falsely positive for HCV antibody. Also,patients with autoimmune liver disease may show a false positive HCV antibody result. Hence it is advisable to confirm a positive antibody result with a supplemental test. A positive result when followed by a positive supplemental test (i.e. HCV-RNA-PCR) suggests active hepatitis C infection.

****End Of Report****
Please visit www.agilusdiagnostics.com for related Test Information for this accession

Sanjeew

Dr.Sanjeew Kumar
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ULR No.775000008259223-0707

SADAR HOSPITAL BOKARO
CAMP 2 BOKARO

Registration No : 20240022112
Visit No : 2/ Last Visit Date : 10/04/2024 12.00 AM / Token No : 12
Room No : Main Building A,OPD Block,Ground,G.Medicine OPD 9

Dr. Aditya
Medicine OPD

Name : **Mr. Jilani Ansari**
Sex/Age : **32Y 2M 24D / M**
Department : Medicine

Registration Amount : **Rs. 5**
Mobile No : **7001422982**
Address :PUNDAG BALI(WEST BENGAL)
Date of Registration : 04/07/2024 09.42 AM

Patient Type : General
Guardian Name : K ANSARI(Father)

MLC Patient : NO

Last Complete Collection Date/Amount : 10/04/2024 10.22 AM/Rs. 5

CBS - 30
10.7.24

Report for Blood Exam -

HIV - Non - Reactive

10/7/24

Prepared By: Mr.
Narendra Kumar Sinha

Date Time: 04/07/2024 09.42 AM

MC-5746

PATIENT NAME : JILANI ANSARI | **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : CR00000044 - AGILUS AGILUS PATHLABS REACH LIMITED OPD PATIENTS SADAR HOSPITAL, BOKORO, SECTOR - 1, BOKORO STEEL CITY, BOKARO 827001 7260813496	ACCESSION NO : **0031XG003935** PATIENT ID : JILAM05079231A CLIENT PATIENT ID : ABHA NO :	AGE/SEX : 32 Years Male DRAWN : 04/07/2024 09:07 [illegible] RECEIVED : 05/07/2024 13:21:22 REPORTED : 05/07/2024 15:02 [illegible]

CLINICAL INFORMATION :

0707XG000210

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
IRON, SERUM			
IRON	61 Low	65 - 175	µg/dL
METHOD : FERENE			

Interpretation(s)
IRON, SERUM-Serum iron test is useful for etio- morphological diagnosis of anemias, in hemochromatosis, in hemosiderosis and in acute iron toxicity. Serum iron is recommended to be correlated with Total Iron Binding Capacity (TIBC) for evaluation of iron deficiency.

****End Of Report****
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A.Chatterjee
Dr,Anwesha Chatterjee
Pathologist

chaitali ray.
Dr. Chaitali Ray, PHD
Biochemist

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ULR No.31000005053166-0021

OPD SLIP

मुस्कान हॉस्पीटल एण्ड रिसर्च सेन्टर

Dr. S. C. Munshi
MBBS, DCH, MD (Paeds)
Consultant Paediatrician & Neonatologist
Time : 9:30 am to 01:30 pm
(Sunday Off)

Dr. Irfan Ansari
MBBS, MS (Gen. Surgery)
Consultant Laparoscopic & Cancer Surgeon
Time : 10:30 am to 02:30 pm
(Friday Evening Off)

Dr. Md. Shahnawaj Anwar
MBBS, MD (Med.)
Consultant Physician
Cardiologist & Diabetologist
Time : 11:00 am to 02:30 pm
07:00 pm to 08:00 pm
(Sunday Evening Off)

Dr. Manoj Kr. Srivastava
MBBS, AFMC (PUNE)
Child Specialist, General Physician & Surgeon
Time : 11:30 am to 02:00 pm

Muskan Ruganalya (P) Ltd.
Undertaking
Muskan SUPERSPECIALITY Centre
Plot No. : S-3, City Centre, Beside M-Bazar, Sector - IV, Bokaro Steel City (Jharkhand)
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- Colonoscopy
- ERCP.

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- Ben Franklin Optical Point

Neuro Surgery Deparment :
- OPD.

Name : Zilani Ansari
Age/Sex: 30/M
Weight

MUSKAN Hospital & Research Centre

09 JUL 2024
Date :

CKD
on MHD

Bokaro

BP - 150/80 mmHg
HR - 88/m
Chest - B/L VBC
CVS - S1 S2

MHD 3/week
Zyrop 10K SC weekly
EIDO inj IV weekly
Amlong 5 OD
Aprezol 20 - 30
Ecokam I 40 BD
Folvite 5 OD
Vitife OD
Shelcal 500 BD

Calve

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