PATIENT NAME : KUMARI SUNITA	**REF. DOCTOR :** DR. SADAR HOSPITAL	
	ACCESSION NO : **0707XG000157**	AGE/SEX : 38 Years Female
	PATIENT ID : KUMAF050785707	DRAWN : 03/07/2024 11:16:31
	CLIENT PATIENT ID:	RECEIVED : 03/07/2024 11:18:42
	ABHA NO :	REPORTED : 06/07/2024 12:30:30

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)	**6.5 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	**2.21 Low**	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT	6.00	4.0 - 10.0	thou/µL
PLATELET COUNT	**97 Low**	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	**19.4 Low**	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	88.0	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.2	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.3	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**15.5 High**	11.6 - 14.0	%
MENTZER INDEX	39.8		
MEAN PLATELET VOLUME (MPV)	8.4	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	75	40 - 80	%
LYMPHOCYTES	20	20 - 40	%
MONOCYTES	02	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	00	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	4.5	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.2	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	**0.12 Low**	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.18	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.8		

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Rep

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

ULR No.775000008246536-0707

PATIENT NAME : KUMARI SUNITA		**REF. DOCTOR :** DR. SADAR HOSPITAL
	ACCESSION NO : **0707XG000157**	AGE/SEX :38 Years Female
	PATIENT ID : KUMAF050785707	DRAWN :03/07/2024 11:16:31
	CLIENT PATIENT ID:	RECEIVED :03/07/2024 11:18:42
	ABHA NO :	REPORTED :06/07/2024 12:30:30

Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY

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

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R	**92 High**	0 - 20	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: Polycythermia 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.

Sanjeew

Dr.Sanjeew Kumar
Consultant-Pathologist &
Laboratory Head

View Details View Report

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

ULR No.775000008246536-0707

PATIENT NAME : KUMARI SUNITA		REF. DOCTOR : DR. SADAR HOSPITAL
	ACCESSION NO : 0707XG000157	AGE/SEX : 38 Years Female
	PATIENT ID : KUMAF050785707	DRAWN : 03/07/2024 11:16:31
	CLIENT PATIENT ID :	RECEIVED : 03/07/2024 11:18:42
	ABHA NO :	REPORTED : 06/07/2024 12:30:30

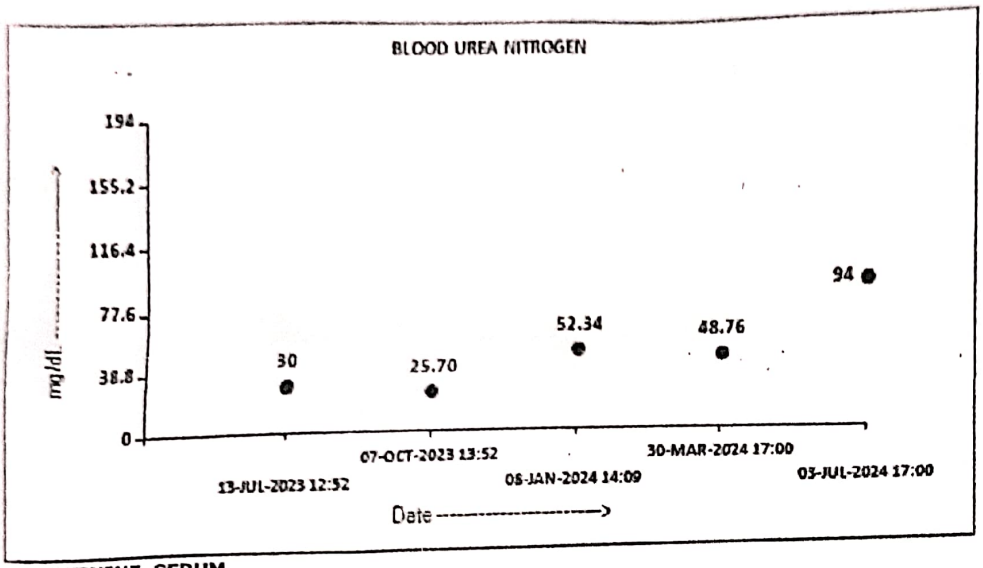
Test Report Status **Final**	Results	Biological Reference Interval	Units

BIOCHEMISTRY

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	**94 High**	6 - 22	mg/dL



CREATININE, SERUM

CREATININE	**9.43 High**	0.6 - 1.2	mg/dL

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Rep...

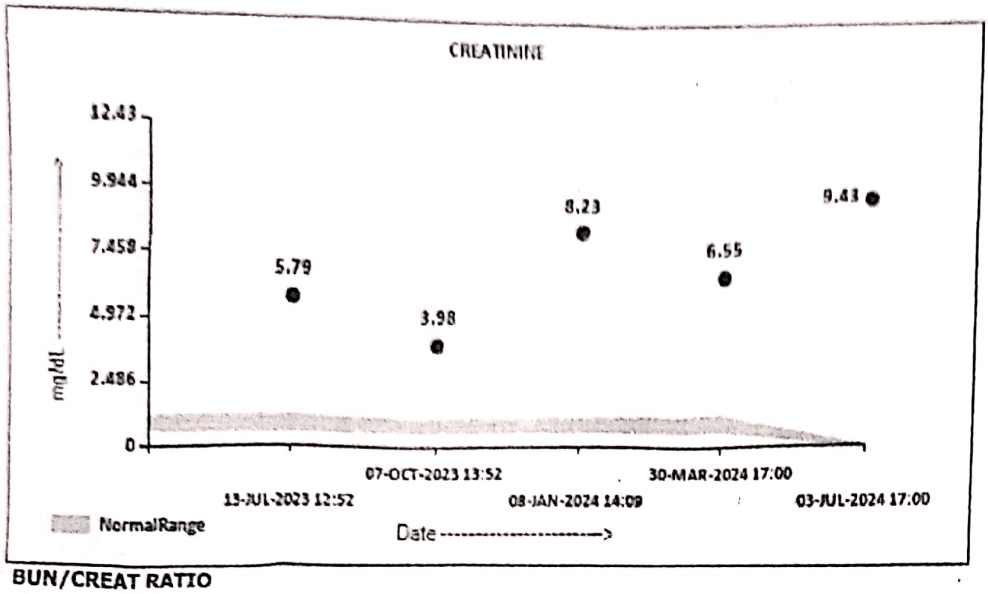
PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008246536-0707

PATIENT NAME : KUMARI SUNITA | **REF. DOCTOR : DR. SADAR HOSPITAL**

ACCESSION NO : 0707XG000157	AGE/SEX : 38 Years Female
PATIENT ID : KUMAF050785707	DRAWN : 03/07/2024 11:16:15
CLIENT PATIENT ID :	RECEIVED : 03/07/2024 11:18:42
ABHA NO :	REPORTED : 06/07/2024 12:30:30

Test Report Status **Final**	Results	Biological Reference Interval	Units



BUN/CREAT RATIO

BUN/CREAT RATIO	9.97	5.0 - 15.0	

CALCIUM, SERUM

CALCIUM	**7.20 Low**	8.4 - 10.4	mg/dL

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	**133.7 Low**	135.0 - 148.0	mmol/L
POTASSIUM, SERUM	4.74	3.5 - 5.3	mmol/L
CHLORIDE, SERUM	104.6	98.0 - 107.0	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

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

ULR No.77500000824653 6-0707

AGNOSTIC REPORT

MC-5746

agilus

PATIENT NAME : KUMARI SUNITA | **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : CR00000048 KIT DOWN - BOKORO SADAR HOSPITAL, BOKORO 827001 9971116367	ACCESSION NO : 0031XG003086 PATIENT ID : KUMAF040786311 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 38 Years Female DRAWN : 03/07/2024 11:07 0 RECEIVED : 04/07/2024 12:43 3 REPORTED : 04/07/2024 13:34 3

CLINICAL INFORMATION :

0707XG000157

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : DIAZONIUM SALT	0.80	0.2 - 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO REACTION	0.30	0.0 - 0.5	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED	0.50	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.2	6.0 - 8.30	g/dL
ALBUMIN METHOD : COLORIMETRIC (BROMCRESOL GREEN)	4.3	3.5 - 5.2	g/dL
GLOBULIN	2.9	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)	17	5 - 34	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	18	0 - 55	U/L
ALKALINE PHOSPHATASE METHOD : PARA-NITROPHENYL PHOSPHATE	**589 High**	40 - 150	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD	19	8 -33	U/L
LACTATE DEHYDROGENASE METHOD : IFCC LACTATE TO PYRUVATE	**238 High**	125 - 220	U/L
URIC ACID, SERUM			
URIC ACID METHOD : URICASE	**7.4 High**	2.6 - 6.0	mg/dL

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give

Page

Dr. Chaitali Ray, PHD
Chief Biochemist cum MRQA

Dr.Anwesha Chatterjee,MD,DipRCPath
(Histopathology)
Pathologist

View Details View

PERFORMED AT :
Agilus Diagnostics Ltd
P S Srijan Tech Park Building, Dn-52, Unit No. 2, Ground Floor, Sector V, Salt Lake,
Kolkata, 700091
West Bengal, India
Tel : 9111591115, Fax : 30203412
CIN - U74899PB1995PLC045956

ULR No.31000005052317-003

PC 5745

PATIENT NAME : KUMARI SUNITA | **REF. DOCTOR : DR. SADAR HOSPITAL**

ACCESSION NO	0707XG000157	AGE/SEX	38 Years Female
PATIENT ID	KUMAF050785707	DRAWN	03/07/2024 11:16:31
CLIENT PATIENT ID		RECEIVED	03/07/2024 11:18:42
ABHA NO		REPORTED	04/07/2024 14:12:11

Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - ANEMIA

SERUM IRON AND TIBC STUDIES

IRON	234 High	50 - 170	µg/dl
METHOD : FERENE			
TOTAL IRON BINDING CAPACITY	268	250 - 450	µg/dl
METHOD : CALCULATED PARAMETER			
% SATURATION	87 High	13 - 45	%

Interpretation(s)
SERUM IRON AND TIBC STUDIES-Total iron binding capacity (TIBC) measures the blood's capacity to bind iron with transferrin and thus is an indirect way of assessing transferrin level.
Taken together with serum iron and percent transferrin saturation this test is performed when they is a concern about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, alterations in liver function (such as cirrhosis, hepatitis, or liver failure) must be considered when performing this test.
Increased in:
- iron deficiency
- acute and chronic blood loss
- acute liver damage
- progesterone birth control pills

Decreased in:
- hemochromatosis
- cirrhosis of the liver
- thalassemia
- anemias of infection and chronic diseases
- nephrosis
- hyperthyroidism

The percent Transferrin saturation = Serum Iron/TIBC x 100
Unsaturated Binding Capacity (UIBC)=TIBC - Serum Iron.
Limitations: Estrogens and oral contraceptives increase TIBC and Asparaginase, chloramphenicol, corticotropin, cortisone and testosterone decrease the TIBC level.

Reference:
1.Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 563, 1314-1315.
2. Wallach's Interpretation of Diagnostic tests, 9th Edition, Ed Mary A Williamson and L Michael Snyder. Pub Lippincott Williams and Wilkins, 2011, 234-235.

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

Dr. Chaitali Ray, PHD
Biochemist

Dr.Anwesha Chatterjee
Pathologist

View Details View Report

PERFORMED AT :
Agilus Diagnostics Ltd
P S Srijan Tech Park Building, Dn-52, Unit No. 2, Ground Floor, Sector V, Salt Lake, Kolkata, 700091
West Bengal, India
Tel : 9111591115, Fax : 30203412
CIN - U74899PB1995PLC045956

ULR No.775000008246536-0031

50 x 2 / 100

PATIENT NAME : KUMARI SUNITA

REF. DOCTOR : DR. SADAR HOSPITAL

ACCESSION NO : **0707XG000157**		AGE/SEX : 38 Years Female
PATIENT ID : KUMAF050785707		DRAWN : 03/07/2024 11:16:31
CLIENT PATIENT ID:		RECEIVED : 03/07/2024 11:18:47
ABHA NO :		REPORTED : 06/07/2024 12:30:30

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	**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
Consultant - Pathologist &
Laboratory Head

View Details View Report

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

ULR No.775000008246536-0707

UHID: 20230025576

SADAR HOSPITAL BOKARO
CAMP 2 BOKARO

CONSULTING ROOM NO :9, TOKEN NO : 15
Clinic Medicine OPD
Days:MON,TUE,WED,THU,FRI,SAT

EHR ID : 23010331003208823

OUT PATIENT RECORD

Name : MS. KUMARI SUNITA
Department : Medicine
Dept No. : 2023/051/0008603
Date of Registration : 19-04-2023 09:42:29 AM
Unit. : 1
Age : 40Y
Billing Type : General
Mobile No : *******497
Address : SEC 12 C, Bokaro, JHARKHAND, INDIA
Patient Type:NON MLC

Fee : 5.00
Sex : Female
W/O M RAM
Email :
Occupation : OTHER
Prepared by:Ms. Suman Kumari

Report for Blood Exam-nt
HIV - Non - Reactive

21/4/23

CBS
01/08/23

Report for Blood Exam-nt
HIV - Non - Reactive

04/08/23

CBS-nt
19/4/23

(8)

R.N.B HOSPITAL & PAL EYE RESEARCH CENTER

Dr. Mukteshwar Rajak
M.B.B.S., M.D (MEDICINE)
D.M. (NEPHROLOGY)
EX. H.O.D (NEPHROLOGY)
JOINT DIRECTOR (BGH)
Life Member API, Life Member ISN
Sr. CONSULTANT NEPHROLOGIST
TRANSPLANT PHYSICIAN

48.6

BP 145/92 mm/Hg
Pulse 107/mt
SPO_2 97%

Date: 09/07/24

Patient Name: Kumari Sumida Age: 40y Sex: F

F/C of • HTN
• CKD 5 on MHD
• 2° Anemia
• Hcv +ve
• Iron over load

HCV 6.5
Serum Iron – 234
TSAT – 37%
S.FP – 585
Hb – 7.44

• iPTH.

Rx
1. Tab Deferasirox 250 1x1 (15)
2. Tab Okamet 50 — (30)
   2 Tab (60) Morning/Lunch/Evening
3. Tab Zolpidem 12.5 — (30) HS
4. Amlodac 10 1— (60)
5. Arkamine 0.1 — (60)
6. Rbustat 150 — (30)
7. Cardivas 6.25 — (30)
8. Prazofix XL 5 — (60)
9. Somipraz-L — (30)
10. Inj C-500 1x1 (10)

9/7/24

Fees Valid Up to 15 days

दवा मिलने का स्थान :
Shubh Vinayak Medicine

Plot No.-180, Coperative Colony

R.N.B HOSPITAL Help line No.
06542 255060, 9153899691