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TEST REPORT

Reg. No :	1612400198	**Reg. Date :**	23-Dec-2016 10:37	**Collected On :**	23-Dec-2016 10:04
Name :	MAULI PATEL			**Report Date :**	23-Dec-2016
Age :	36 Years	**Sex :**	Female	**Dispatch At :**	
Ref. By :	DR. Self				
Location :				**Tele No:**	8160019793

Parameter	Result	Unit	Reference Interval
S.Iron Level	93.0	ug/dL	37 - 170
Total Iron Binding Capacity	327.0	ug/dL	265 - 497
% TRANSFERRIN SATURATION	28.44	%	20 - 50

HAEMOGLOBIN A1 C ESTIMATION

HBA1c (GLYCOSYLATED HEMOGLOBIN)	4.9	%	Non Diabetic Level :<6.0 Near Normal Glycemia :6.0-7.0 Goal for Diabetics :<7.0 Good Control :7.0-8.0 Poor Control,Action Suggested:>8.0

The hemoglobin A1c test also called HbA1c, glycated hemoglobin test or glycohemoglobin - is the important test for assessment of long term glucose control (also called Glycemic control) and is a better indication of long term glycemic control as than blood glucose determination. Hemoglobin A1c provides an average of your blood sugar control over a six to twelve week period.

People with diabetes should have this test every three months to determine whether their blood sugars have reached the target level of control. Those who have their diabetes under good control maybe able to wait longer between the blood tests, but experts recommend checking atleast two times a year. Patients with diseases that affect hemoglobin such as anaemia may get abnormal results with this test. Other abnormalities that can affect the results of the hemoglobin A1c include supplements such as Vitamins C & E and high cholestrol levels. Kidney and liver diseases may also affect the result of the hemoglobin A1c test.

Mean Blood Glucose	93.93	mg/dL

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(M.D. Path.)

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LIVER FUNCTION TEST

Parameter	Result	Unit	Reference Interval
S.Billirubin			
Total Billirubin	0.42	mg/dL	0.2 - 1.3
Direct Bilirubin	0.22	mg/dL	0.0 - 0.2
Indirect Bilirubin	0.20	mg/dL	0.0 - 0.8
S.G.P.T	43.5	IU/L	21 - 49
S.G.O.T	17.9	IU/L	15 - 37
S.Alkaline Phosphatase	78.49	U/L	New born(1-3 days):95-368 2months-13 yrs:115-403 14-18 yrs:58-124 Adults: 39-118
S.Proteins			
Total Protein	6.60	gm/dL	6.4 - 8.2
Albumin	4.90	gm/dL	3.4 - 5
Globulin	1.70	gm/dL	2.8 - 3.3
Albumin Globulin Ratio	2.88	gm/dL	
GGT	16.9	IU/L	5 - 85

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Parameter	Result	Unit	Reference Interval
BUN			
Blood Urea Nitrogen	9.6	mg/dL	7 - 18
CALCIUM			
S.Calcium	9.1	mg/dL	8.8 - 10.2
CREATININE			
S.Creatinine	0.81	mg/dL	0.6 - 1.30
URIC ACID			
Uric Acid	2.75	mg/dL	2.6 - 7.2
LIPID PROFILE			
Serum Cholesterol	249.0	mg/dL	Desirable level/low risk : <200 Borderline level/moderate risk : 200-239 Elevated level/high risk : >240
Serum Triglycerides	75.0	mg/dL	35 - 135
HDL Cholesterol	84.5	mg/dL	42 - 88
S. LDL Cholesterol	149.50	mg/dL	Desirable level/low risk : <130 Borderline level/moderate risk : 130-159 Elevated level/high risk : >160
S. VLDL Cholesterol	15.00	mg/dL	Upto 34
Total Lipids	573.00	mg/dL	400 - 700
Chol./HDL Ratio	2.947	mg/dL	
LDL/HDL Ratio	1.769	mg/dL	Desirable level/low risk : 0.5-3.0 Borderline level/moderate risk : 3.0-6.0 Elevated level/high risk : >6.0

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Parameter	Result	Unit	Reference Interval
COMPLETE BLOOD COUNT			
Hemoglobin	12.8	gm%	12.0 - 16.0
Total RBC Count	4.98	mil/cumm	4.2 - 6.2
Blood Indices			
H.CT	39.2	%	26 - 50
M.C.V.	78.7	fL	80 - 96
M.C.H.	25.7	pg	26 - 38
M.C.H.C.	32.7	%	31 - 37
R.D.W.	15.5	%	11.6 - 14.6
Total WBC Count	8820	/cmm	4000 - 10000
Platelets Count	292000	/cmm	150000 - 450000
Differential WBC Count			
Polymorphs	66	%	40 - 70
Lymphocytes	31	%	20 - 40
Monocytes	02	%	2 - 6
Eosinophils	01	%	1 - 7
Basophils	00	%	0 - 2
Smear Study - RBC	RBC's are Predominantly Microcytic & Normochormic.		
Smear Study - WBC	WBC count is normal.		
Smear Study - Platelets	Platelets are adequate		
Smear Study - PS for MP	No Blood Parasites are seen.		

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Parameter	Result	Unit	Reference Interval

THYROID FUNCTION TESTS

THYROID STIMULATING HORMONE (TSH)	3.42	MicrolU/ml	0.35 - 4.94

Thyroid Stimulating Hormone is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentration of FT3(Free T3) and FT4(Free T4),it is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary(hypothalamic) hypothyroidism. In primary hypothyroidism TSH Levels are significantly elevated, while in secondary and tertiary hypothyroidism TSH levels are Low.

For TSH value Between 5.5 to 15 uIU/ml clinical correlation and repeat test with new sample is advised as many physiological factors can falsely elevate TSH.

TSH Values may be transiently altered due to non thyroidal illness like severe infection, liver disease, renal and heart failure, severe burns, trauma, surgery etc.

TRIIODOTHYRONINE T3	0.81	ng/mL	0.58 - 1.59
THYROXIN T4	5.48	µg/dL	4.87 - 11.72

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Parameter	Result	Unit	Reference Interval
VITAMIN D	30.7	ng/mL	Deficiency : <10 Insufficiency : 10 - 30 Sufficiency : 30 - 100 Toxicity : >100

Vitamin D is a fat soluble hormone involved in the intestinal absorption and deregulation of calcium. It is synthesized by skin when sunlight strikes bare skin. It can also be ingested from animal sources. Vitamin D is bound to the binding protein (albumin and vitamin D binding protein) and carried to the liver. In the liver it is transformed in to 25 hydroxy-vitamin D (calcidiol), which is the primary circulating and the most commonly measured form in serum. Then in the kidney it is transformed in to 1,25 dihydroxy-vitamin D (calcitriol), which is the biologically active form.
Vitamin D plays a vital role in the formation and maintenance of strong and healthy bones. Vitamin D deficiency has long been associated with rickets in children and osteomalacia in adults. Long term insufficiency of calcium and vitamin D leads to osteoporosis. There have been multiple publications linking vitamin D deficiency to several disease states, such as cancer, cardiovascular disease, diabetes, and autoimmune diseases.

VITAMIN B12	488.0	pg/mL	187 - 883

(Method: Chemiluminescence.)

Dietary sources of Vitamin B12 are meat, eggs, milk and milk products. Vitamin B12 requires intrinsic factors for absorption from the intestine.

B12 deficiency leads to hematological and neurological abnormalities. Decreased serum B12 levels causes increased excretion of methylmalonic acid. The impaired DNA synthesis associated with Vitamin B12 deficiency causes macrocytic anaemia. In severe cases it is characterized by abnormal maturation of erythrocytes, myeloid precursors and megakaryocytes in the bone marrow, which results in the pancytopenia. It is advised to withhold Vitamin B12 injection before the blood is drawn. Blood collected after Vitamin B12 injection interferes with the result. Preservatives such as fluorides and ascorbic acid interfere with this assay. Excessive exposure of the specimen to light may alter Vitamin B12 result.

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