

REPORT

Name	: Mrs. SWETHA	Sample ID	: 24753553
Age/Gender	: 32 Years/Female	Reg. No	: 0312311050003
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 05-Nov-2023 08:05 AM
Primary Sample	: Whole Blood	Received On	: 05-Nov-2023 02:32 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 05-Nov-2023 03:11 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

HAEMATOLOGY

Test Name	Results	Units	Ref. Range	Method
Complete Blood Picture(CBP)				
Haemoglobin (Hb)	9.4	g/dL	12-15	Cynmeth Method
Haematocrit (HCT)	30.4	%	40-50	Calculated
RBC Count	4.48	10 ¹² /L	4.5-5.5	Cell Impedence
MCV	68	fl	81-101	Calculated
MCH	20.9	pg	27-32	Calculated
MCHC	30.9	g/dL	32.5-34.5	Calculated
RDW-CV	19.0	%	11.6-14.0	Calculated
Platelet Count (PLT)	418	10 ⁹ /L	150-410	Cell Impedence
Total WBC Count	6.8	10 ⁹ /L	4.0-10.0	Impedence
Differential Leucocyte Count (DC)				
Neutrophils	61	%	40-70	Cell Impedence
Lymphocytes	32	%	20-40	Cell Impedence
Monocytes	05	%	2-10	Microscopy
Eosinophils	02	%	1-6	Microscopy
Basophils	00	%	1-2	Microscopy
Absolute Neutrophils Count	4.15	10 ⁹ /L	2.0-7.0	Impedence
Absolute Lymphocyte Count	2.18	10 ⁹ /L	1.0-3.0	Impedence
Absolute Monocyte Count	0.34	10 ⁹ /L	0.2-1.0	Calculated
Absolute Eosinophils Count	0.14	10 ⁹ /L	0.02-0.5	Calculated
Absolute Basophil ICount	0.00	10 ⁹ /L	0.0-0.3	Calculated
Morphology	Anisocytosis with Microcytic hypochromic anemia with Thrombocytosis			PAPs Staining



*TESTS CONDUCTED @ CENTRAL LAB, HYDERABAD

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Swarnabala . M
DR.SWARNA BALA
MD PATHOLOGY

REPORT

Name	: Mrs. SWETHA	Sample ID	: 24753555, 24753556, 247535
Age/Gender	: 32 Years/Female	Reg. No	: 0312311050003
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 05-Nov-2023 08:05 AM
Primary Sample	: Whole Blood	Received On	: 05-Nov-2023 02:32 PM
Sample Tested In	: Plasma-NaF(F), Plasma-NaF(PP),	Reported On	: 05-Nov-2023 04:03 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Glucose Fasting (F)	100	mg/dL	70-100	GOD-POD

Interpretation of Plasma Glucose based on ADA guidelines 2018

Diagnosis	FastingPlasma Glucose(mg/dL)	2hrsPlasma Glucose(mg/dL)	HbA1c(%)	RBS(mg/dL)
Prediabetes	100-125	140-199	5.7-6.4	NA
Diabetes	> = 126	> = 200	> = 6.5	>=200(with symptoms)

Reference: Diabetes care 2018:41(suppl.1):S13-S27

Glucose Post Prandial (PP)	128	mg/dL	70-140	Hexokinase (HK)
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Interpretation of Plasma Glucose based on ADA guidelines 2018

Diagnosis	FastingPlasma Glucose(mg/dL)	2hrsPlasma Glucose(mg/dL)	HbA1c(%)	RBS(mg/dL)
Prediabetes	100-125	140-199	5.7-6.4	NA
Diabetes	> = 126	> = 200	> = 6.5	>=200(with symptoms)

Reference: Diabetes care 2018:41(suppl.1):S13-S27

- Postprandial glucose level is a screening test for Diabetes Mellitus
- If glucose level is >140 mg/dL and <200 mg/dL, then GTT (glucose tolerance test) is advised.
- If level after 2 hours = >200 mg/dL diabetes mellitus is confirmed.
- Advise HbA1c for further evaluation.



Dr. Vaishnavi
DR. VAISHNAVI
MD BIOCHEMISTRY

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CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Creatinine -Serum	0.60	mg/dL	0.60-1.10	Sarcosine oxidase

Interpretation:

- This test is done to see how well your kidneys are working. Creatinine is a chemical waste product of creatine. Creatine is a chemical made by the body and is used to supply energy mainly to muscles.
- **A higher than normal level may be due to:**
- Renal diseases and insufficiency with decreased glomerular filtration, urinary tract obstruction, reduced renal blood flow including congestive heart failure, shock, and dehydration; rhabdomyolysis can cause elevated serum creatinine.
- **A lower than normal level may be due to:**
- Small stature, debilitation, decreased muscle mass; some complex cases of severe hepatic disease can cause low serum creatinine levels. In advanced liver disease, low creatinine may result from decreased hepatic production of creatinine and inadequate dietary protein as well as reduced muscle mass.

Result rechecked and verified for abnormal cases

*** End Of Report ***

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Excellence In Health Care



Dr. Vaishnavi
DR. VAISHNAVI
MD BIOCHEMISTRY

REPORT

Name	: Mrs. SWETHA	Sample ID	: 24753557
Age/Gender	: 32 Years/Female	Reg. No	: 0312311050003
Referred by	: Dr. Nivedita Ashrit MD (Obs/Gyn)	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 05-Nov-2023 08:05 AM
Primary Sample	: Whole Blood	Received On	: 05-Nov-2023 02:32 PM
Sample Tested In	: Serum	Reported On	: 05-Nov-2023 03:53 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
TSH -Thyroid Stimulating Hormone	0.25	µIU/mL	0.35-5.5	CLIA

Pregnancy & Cord Blood

TSH (Thyroid Stimulating Hormone (µIU/mL))	
First Trimester	: 0.24-2.99
Second Trimester	: 0.46-2.95
Third Trimester	: 0.43-2.78
Cord Blood	: 2.3-13.2

- TSH is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production.
- TSH interacts with specific cell receptors on the thyroid cell surface and exerts two main actions. The first action is to stimulate cell reproduction and hypertrophy. Secondly, TSH stimulates the thyroid gland to synthesize and secrete T3 and T4
- The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low
- TRH stimulation differentiates secondary and tertiary hypothyroidism by observing the change in patient TSH levels. Typically, the TSH response to TRH stimulation is absent in cases of secondary hypothyroidism, and normal to exaggerated in tertiary hypothyroidism
- Historically, TRH stimulation has been used to confirm primary hyperthyroidism, indicated by elevated T3 and T4 levels and low or undetectable TSH levels. TSH assays with increased sensitivity and specificity provide a primary diagnostic tool to differentiate hyperthyroid from euthyroid patients.

Correlate Clinically.

Result rechecked and verified for abnormal cases

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*** End Of Report ***



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