

**REPORT**

Name	: Mrs. M SATHYAVATHI	Sample ID	: A0934404
Age/Gender	: 55 Years/Female	Reg. No	: 0312409170023
Referred by	: Dr. RAVI SHANKAR	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 17-Sep-2024 02:42 AM
Primary Sample	: Whole Blood	Received On	: 17-Sep-2024 04:10 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 17-Sep-2024 04:36 PM
Client Address	: Kimtee colony ,Gokul Nagar, Tarnaka	Report Status	: Final Report

**HAEMATOLOGY**

Test Name	Results	Units	Ref. Range	Method
<b>Complete Blood Picture(CBP)</b>				
Haemoglobin (Hb)	<b>8.6</b>	g/dL	12-15	Cynmeth Method
Haematocrit (HCT)	<b>28.9</b>	%	40-50	Calculated
RBC Count	<b>3.02</b>	10 <sup>12</sup> /L	3.8-4.8	Cell Impedence
MCV	96	fl	81-101	Calculated
MCH	28.3	pg	27-32	Calculated
MCHC	<b>29.6</b>	g/dL	32.5-34.5	Calculated
RDW-CV	<b>17.0</b>	%	11.6-14.0	Calculated
Platelet Count (PLT)	<b>501</b>	10 <sup>9</sup> /L	150-410	Cell Impedence
Total WBC Count	6.7	10 <sup>9</sup> /L	4.0-10.0	Impedence
<b>Differential Leucocyte Count (DC)</b>				
Neutrophils	70	%	40-70	Cell Impedence
Lymphocytes	23	%	20-40	Cell Impedence
Monocytes	05	%	2-10	Microscopy
Eosinophils	02	%	1-6	Microscopy
Basophils	00	%	1-2	Microscopy
Absolute Neutrophils Count	4.69	10 <sup>9</sup> /L	2.0-7.0	Impedence
Absolute Lymphocyte Count	1.54	10 <sup>9</sup> /L	1.0-3.0	Impedence
Absolute Monocyte Count	0.34	10 <sup>9</sup> /L	0.2-1.0	Calculated
Absolute Eosinophils Count	0.13	10 <sup>9</sup> /L	0.02-0.5	Calculated
Absolute Basophil ICount	0.00	10 <sup>9</sup> /L	0.0-0.3	Calculated
Morphology	Anisocytosis with Microcytic hypochromic anemia with Thrombocytosis			PAPs Staining



Swannabala - M  
DR.SWARNA BALA  
MD PATHOLOGY

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Primary Sample	: Whole Blood	Received On	: 17-Sep-2024 04:15 PM
Sample Tested In	: Serum	Reported On	: 17-Sep-2024 05:53 PM
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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
<b>Creatinine -Serum</b>	0.63	mg/dL	0.60-1.10	Jaffes Kinetic

**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 \*\*\*

Laboratory is NABL Accredited



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**DR. VAISHNAVI**  
**MD BIOCHEMISTRY**

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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
<b>Liver Function Test (LFT)</b>				
Bilirubin(Total)	0.61	mg/dL	0.3-1.2	Diazo
Bilirubin (Direct)	<b>0.31</b>	mg/dL	0.0 - 0.3	Diazo
Bilirubin (Indirect)	0.3	mg/dL	0.2-1.0	Calculated
Aspartate Aminotransferase (AST/SGOT)	33.7	U/L	15-37	IFCC UV Assay
Alanine Aminotransferase (ALT/SGPT)	17.3	U/L	0-55	IFCC with out (P-5-P)
Alkaline Phosphatase(ALP)	<b>188.1</b>	U/L	30-120	Kinetic PNPP-AMP
Gamma Glutamyl Transpeptidase (GGTP)	<b>79.9</b>	U/L	5-55	IFCC
Protein - Total	7.49	g/dL	6.4-8.2	Biuret
Albumin	3.5	g/dL	3.4-5.0	Bromocresol Green (BCG)
Globulin	3.99	g/dL	2.0-4.2	Calculated
A:G Ratio	0.88	%	0.8-2.0	Calculated
SGOT/SGPT Ratio	1.95			

**Alanine Aminotransferase(ALT)** is an enzyme found in liver and kidneys cells. ALT helps create energy for liver cells. Damaged liver cells release ALT into the bloodstream, which can elevate ALT levels in the blood.

**Aspartate Aminotransferase (AST)** is an enzyme in the liver and muscles that helps metabolizes amino acids. Similarly to ALT, elevated AST levels may be a sign of liver damage or liver disease.

**Alkaline phosphate (ALP)** is an enzyme present in the blood. ALP contributes to numerous vital bodily functions, such as supplying nutrients to the liver, promoting bone growth, and metabolizing fat in the intestines.

**Gamma-glutamyl Transpeptidase (GGTP)** is an enzyme that occurs primarily in the liver, but it is also present in the kidneys, pancreas, gallbladder, and spleen. Higher than normal concentrations of GGTP in the blood may indicate alcohol-related liver damage. Elevated GGTP levels can also increase the risk of developing certain types of cancer.

**Bilirubin** is a waste product that forms when the liver breaks down red blood cells. Bilirubin exits the body as bile in stool. High levels of bilirubin can cause jaundice - a condition in which the skin and whites of the eyes turn yellow- and may indicate liver damage.

**Albumin** is a protein that the liver produces. The liver releases albumin into the bloodstream, where it helps fight infections and transport vitamins, hormones, and enzymes throughout the body. Liver damage can cause abnormally low albumin levels.



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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
<b>Iron Profile-I</b>				
Iron(Fe)	67	µg/dL	50-170	Ferrozine
Total Iron Binding Capacity (TIBC)	362	µg/dL	250-450	Ferrozine
Transferrin	253.15	mg/dL	250-380	Calculated
Iron Saturation((% Transferrin Saturation)	18.51	%	15-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	295	ug/dL	110-370	FerroZine

**Interpretation:**

- Serum transferrin (and TIBC) high, serum iron low, saturation low. Usual causes of depleted iron stores include blood loss, inadequate dietary iron. RBCs in moderately severe iron deficiency are hypochromic and microcytic. Stainable marrow iron is absent. Serum ferritin decrease is the earliest indicator of iron deficiency if inflammation is absent.
- **Anemia of chronic disease:** Serum transferrin (and TIBC) low to normal, serum iron low, saturation low or normal. Transferrin decreases with many inflammatory diseases. With chronic disease there is a block in movement to and utilization of iron by marrow. This leads to low serum iron and decreased erythropoiesis. Examples include acute and chronic infections, malignancy and renal failure.
- **Sideroblastic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron normal to high, saturation high.
- **Hemolytic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron high, saturation high.
- **Hemochromatosis:** Serum transferrin (and TIBC) slightly low, serum iron high, saturation very high.
- **Protein depletion:** Serum transferrin (and TIBC) may be low, serum iron normal or low (if patient also is iron deficient). This may occur as a result of malnutrition, liver disease, renal disease.
- **Liver disease:** Serum transferrin variable; with acute viral hepatitis, high along with serum iron and ferritin. With chronic liver disease (eg, cirrhosis), transferrin may be low. Patients who have cirrhosis and portacaval shunting have saturated TIBC/transferrin as well as high ferritin.

Correlate Clinically.

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