



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		
Referred By	: NA		MDR-LYK
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:44PM	Approved Date	:13-Oct-2026 04:18PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Simplycare THS 3

Haematology

Test Description	Observed Value	Biological Reference Interval
HbA1c (Glycated Haemoglobin) HPLC	6.3	4.5-6.4 %

REMARKS

In vitro quantitative determination of **HbA1c** in whole blood is utilized in long term monitoring of glycemia. The **HbA1c** level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of **HbA1c** be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of **HbA1c** should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.

Type of results	A1c	Estimated average blood glucose level (mg/dL)	Guidance for Known Diabetics
Normal A1c results	< 5.7%	< 117	Good Control
Prediabetes A1c results	5.7 to 6.4%	117 to 137	Fair Control
Diabetes A1c results	> 6.4%	> 137	Unsatisfactory Control

Note: If variant hemoglobin is observed in HbA1c HPLC screen, HbA1c levels may not truly represent in vivo condition. In such condition HbA1c analysis by HPLC may not be the method of choice. You are advised to consult your referring physician and discuss the alternative tests as suggested below.

Advised

1. To follow patient for glycemic control test like fructosamine or glycated albumin may be performed instead.
2. Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.

Mean Plasma Glucose Calculated	134.11	70-137 mg/dL
--	--------	--------------

Mean Plasma Glucose is based on estimated Average Glucose (eAG) value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		
Referred By	: NA		MDR-LYK
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:44PM	Approved Date	:13-Oct-2026 04:29PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
Complete Blood Count [6 part Sysmex XN-550] EDTA whole blood		
Haemoglobin (Hb) Cyanide-free SLS	14.6	13.5-17.5 g/dL
RBC Count Hydro-dynamically Focused Impedance	5.20	4.7-6.1 $10^6/\mu\text{L}$
Packed Cell Volume RBC Pulse Height	48.6	41-53 %
MCV Calculated	92.5	80-100 fL
MCH Calculated	27.7	26-34 pg
MCHC Calculated	30.0	31-37 g/dL
TLC (Total Leucocyte Count) Flow Cytometry	7380	4000 - 11000 Cells/ μL
Differential Leucocyte Count		
Neutrophil Microscopy/Flow Cytometry	49.4	40-80 %
Lymphocyte Microscopy/Flow Cytometry	41.00	24 - 44 %
Eosinophils Microscopy/Flow Cytometry	3.5	01-06 %
Monocytes Microscopy/Flow Cytometry	6.0	3-6 %
Basophils Microscopy/Flow Cytometry	0.1	0-1 %
IG%	0.1	
Absolute Neutrophil Count	3.60	$2.0-7.0 \times 10^3 /\mu\text{L}$
Absolute Lymphocyte Count	3.00	$1.5-4.0 \times 10^3/\mu\text{L}$
Absolute Eosinophil Count	0.30	$0.02-0.50 \times 10^3 \text{ cells}/\mu\text{L}$
Absolute Basophil Count	0.00	$0.00-0.00 \times 10^3 \text{ cells}/\mu\text{L}$
Absolute Monocyte Count	0.40	$0.2-1.0 \times 10^3 \text{ cells}/\mu\text{L}$
IG	0.00	



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No. : - 2610009213 Age/Gender : 44 Yrs/Male
Pt's Name : Mr. SANJEEV CHAUDHARY MDR-LYK
Referred By : NA
Sample Collection Date/Time : 13-Oct-2026 Date : 13-Oct-2026
Sample Receiving Date/Time : 13-Oct-2026 03:44PM Approved Date : 13-Oct-2026 04:29PM
Sample From : MDR-LYKA PATHOLOGY CLINIC Report Print Time : 13-Oct-2026 06:04PM

Platelet Count 3.30 1.50-4.50 Lakh/uL
Electrical Impedance
Mean Platelet Volume 11.90
PCT 0.40 0.10-0.28 %
Calculated
PDW 19.0 9.0-17.0 fL
Calculated
P-LCR 34.10
RDW-CV 14.6 11.5-14.5 %
Dc Detection Method (Calculated)
RDW-SD 43.6 39.0-46.0 fl
Electrical Impedance

Interpretation :

Causes of low Hb include:	Causes of high Hb include:
Iron deficiency anemia, Vitamin deficiency anemia. (B12/Folic acid), Anemia of inflammation, Aplastic anemia, Anemias associated with bone marrow disease, Hemolytic anemia etc	Smoking, COPD (chronic obstructive pulmonary disease) exacerbation, Dehydration, Emphysema, Heart failure, Polycythemia vera
Causes of low WBC include:	Causes of high WBC include:
Cancer (caused by chemotherapy treatments), Bone marrow disorders or damage, Autoimmune disorders (problems with the immune system in which the body attacks itself), such as lupus, Infections (including tuberculosis and HIV), Immune system conditions, Crohn's disease, Malnutrition, Radiation treatments for cancer, Rheumatoid arthritis, Vitamin deficiencies, Liver damage and/or enlarged spleen.	Infection, Inflammation, Injury, Emotional stress, Labor, Pregnancy, Smoking, Allergic reactions, Excessive exercise, A bone marrow or immune disorder, Certain cancers, such as acute or chronic leukemia
Causes of low Platelets include:	Causes of high Platelets include:
Leukemia and other cancers, Some types of anemia, Viral infections such as Dengue, Hepatitis C or HIV, Chemotherapy drugs and radiation therapy, Heavy alcohol consumption, ITP	Acute bleeding and blood loss, Cancer, Infections, Iron deficiency, Removal of your spleen, Inflammatory disorders, such as rheumatoid arthritis, sarcoidosis or inflammatory bowel disease, Surgery or other type of trauma, Essential thrombocythemia

Instrument : Fully automated bidirectional hematology analyser (6 part differential Sysmex XN-550)

Method : Hematology analyses according to the Hydrodynamic Focussing [DC method], Flow Cytometry Method [Using a semiconductor laser], and SLS- hemoglobin method.

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Biochemistry

Test Description	Observed Value	Biological Reference Interval
RA FACTOR		
RA Factor Immunoturbidimetric assay.	5.29	<12.0 IU/mL
INTERPRETATION		
ADVANTAGES OF QUANTITATION		
Exact concentrations of RA Factor facilitate the following:		
*Accurate staging of disease.		
*Precise prognosis and indication of complications..		
*Adjustment of dose for treatment and follow up of treatment .		
REMARKS		
*RA factor has been demonstrated in approximately 80 % of patients with rheumatoid arthritis.		
*False positive results may occur in hepatitis, sarcoidosis, cirrhosis of liver.		
Sjogren's syndrome, acute bacterial and viral infection.		
*Diagnosis of rheumatoid arthritis should be made in conjunction with complete clinical evaluation.		

*** End Of Report ***

Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 04:12PM	Approved Date	:13-Oct-2026 05:19PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
Blood Glucose Fasting Fluoride plasma		
Blood Glucose Fasting Hexokinase	91.5	F - 60 - 110 mg/dL PP - 70 - 140 mg/dL R - 80 - 140 mg/dL mg/dL mg/dL

Interpretation (In accordance with the American diabetes association guidelines):

- A fasting plasma glucose level below 100 mg/dL is considered normal.
- A fasting plasma glucose level between 100-126 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients.
- A fasting plasma glucose level of above 126 mg/dL is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dL on both the occasions is confirmatory of a diabetic state.

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
CRP (C-reactive protein)-Quantitative		
CRP (C-Reactive Protein)-Quantitative Turbidimetric Immunoassay	11.70	0-6 mg/L
Comments: A high level of CRP in the blood is a sign that there may be an inflammatory process occurring in the body. Inflammation itself isn't typically a problem, but it can indicate a host of other health concerns, including infection, arthritis, kidney failure, and pancreatitis. High CRP levels may put patients at increased risk for coronary artery disease, which can cause a heart attack.		

*** End Of Report ***

Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
GLOMERULAR FILTRATION RATE (GFR) Serum		
Creatinine	0.80	0.7-1.20 mg/dL
Photometric		
Glomerular Filtration Rate (GFR)	113.00	>60 mL/min mL/min
Calculated		
Interpretation:-		
Age in years	GFR in mL/min/1.73m2	
20 - 29	116	
30 - 39	107	
40 - 49	99	
50 - 59	93	
60 - 69	85	
>=70	75	
NOTE:-		
* National Kidney Disease Education program recommends the use of MDRD equation to estimate or predict GFR in adults (>=20 years) with chronic Kidney Disease (CKD).		
* MDRD equation is most accurate for GFR <=60 mL/min/1.73m2		
* Recalculation of estimated GFR is required for African American race.		
CKD Stage	Description	GFR (mL/min/1.73m2)
0	Normal Kidney Function	>90
1	Kidney damage with normal or high GFR	>90
	cells or casts seen in urine	
2	Mild decrease in GFR	60 - 89
3	Moderate decrease in GFR	30 - 59
4	Severe decrease in GFR	15 - 29
5	Kidney Failure	<15
Associated Findings		
		No proteinuria
		Presence Protein, Albumin,
Comments :-		
Modification of diet in renal disease (MDRD) equation is most thoroughly validated an superior to all the other method for estimation of GFR. It does not require weight as a variable and yields an estimated GFR normalized to 1.73m2 body surface area. Using serum creatinine alone gives a poor inference of GFR because they are inversely related and effects of age, sex and race on creatinine production complicate interpretation. For African races a modified formula is used for calculation of GFR.		

*** End Of Report ***

Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
Iron Profile Serum		
Iron, Serum Colorimetric	57.30	65.00-175.00 ug/dL
Total Iron Binding capacity Spectro-photometry	334	250-400 ug/dL
Unsaturated Iron Binding Capacity	276.20	110.0-370.0 ug/dL
Transferrin Saturation % Calculated	17.18	14-50% %
Comments		
Useful for screening for chronic iron overload diseases, particularly hereditary hemochromatosis. Serum iron, total iron-binding capacity, and percent saturation are widely used for the diagnosis of iron deficiency. However, serum ferritin is a much more sensitive and reliable test for demonstration of iron deficiency.		
Ingested iron is absorbed primarily from the intestinal tract and is temporarily stored in the mucosal cells as Fe(III)-ferritin. Ferritin provides a soluble protein shell to encapsulate a complex of insoluble ferric hydroxide-ferric phosphate. On demand, iron is released into the blood by mechanisms that are not clearly understood, to be transported as Fe(III)-transferrin. Transferrin is the primary plasma iron transport protein, which binds iron strongly at physiological pH. Transferrin is generally only 25% to 30% saturated with iron. The additional amount of iron that can be bound is the unsaturated iron-binding capacity (UIBC). The total iron binding capacity (TIBC) can be indirectly determined using the sum of the serum iron and UIBC. Knowing the molecular weight of the transferrin and that each molecule of transferrin can bind 2 atoms of iron, TIBC and transferrin concentration is interconvertible. Percent saturation is usually normal or increased in persons who are iron deficient, pregnant, or are taking oral contraceptive medications. Persons with chronic inflammatory processes, hemochromatosis, or malignancies generally display low transferrin.		
In hereditary hemochromatosis, serum iron is usually >150 ug/dL and percent saturation is >60%. In advanced iron overload states, the percent saturation often is >90%.		
Cautions		
Measurement of serum iron, iron-binding capacity, and percent saturation should not be used as a test for iron deficiency. It is often unreliable for this purpose.		

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
LIVER FUNCTION TEST (LFT) Serum		
Bilirubin, Total	0.30	0.30 to 1.20 mg/dL
Diazo		
Bilirubin Direct.	0.20	0.00-0.20 mg/dL
Diazo		
Bilirubin, Indirect calculated	0.10	0.10-1.00 mg/dL
SGPT (ALT)	56.60	0.00-42.00 IU/L
IFCC without pyridoxal phosphate		
SGOT (AST)	27.50	0.00-37.00 IU/L
IFCC without pyridoxal phosphate		
ALT/AST Ratio Calculated	2.06	Ratio
Alkaline Phosphatase (ALP)	90.0	53.0-128.0 U/L
PNP AMP Kinetic		
Protein, Total	7.50	6.0-8.30 g/dL
Biuret		
Albumin	4.3	2.8-4.4 g/dL
BCG		
Globulin	3.20	2.30-3.50 gm/dL
Calculated		
A/G Ratio	1.34	1.3-1.7
Calculated		
Gamma Glutamyl Transferase,(GGT)	36.20	12-64 U/L
L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrat		
Equipment Used: Cobas c303 Biochemistry Analyzer Integrated System		
Equipment measurement : Colorimetric/Rate,Potentiometric (Direct ISEs),Immuno-rate,Turbidimetric,Enhanced Chemiluminescence		
COMMENT : Please correlate with clinical conditions and drug history. This report is not valid for medico legal purpose.		
If the results of the tests are alarming or unexpected, please contact immediately		

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		
Referred By	: NA		MDR-LYK
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
KFT - Kidney Function Test, Serum		
Urea, Blood	15.20	13.00-43.00 mg/dL
Urease-GLDH		
Blood Urea Nitrogen (BUN)	7.09	7.00-18.00 mg/dL
Calculated		
Creatinine	0.80	0.70-1.20 mg/dL
Spectrophotometry		
Uric Acid (UA)	3.20	3.60-7.70 mg/dL
Uricase		
Protein, Total	7.50	6.00-8.30 g/dL
Biuret		
Sodium	143.7	136.0-149.0 mmol/L
Ion Selective Electrode		
Potassium	3.80	3.50-5.50 mmol/L
Ion Selective Electrode		
Chloride (Cl)	102.90	98.0-109.0 mmol/L
Ion Selective Electrode		
Calcium	9.50	8.40-10.40 mg/dL
Aresenazo		
Equipment Used: Cobas c303 Biochemistry Analyzer Integrated System		
Equipment measurement : Colorimetric/Rate, Potentiometric (Direct ISEs), Immuno-rate, Turbidimetric, Enhanced Chemiluminescence		
COMMENT :		
Tests results are created by fully/semi automated equipments.		
This is only a professional opinion, not the diagnosis.		
Please correlate with clinical conditions and drug history.		
This report is not valid for medico legal purpose.		
If the results of the tests are alarming or unexpected, please contact immediately.		

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:56PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
LIPID PROFILE Serum		
Triglyceride	168.0	40.0-160.0 mg/dL
GPO (Trinders)		
Total Cholesterol	250.00	<200.0 mg/dL
CHOD-PAP		
HDL Cholesterol	45.50	35.3-79.5 mg/dL
CHOD-CHOD		
VLDL Cholesterol	33.6	4.7-21.1 mg/dL
Calculated		
LDL Cholesterol	170.9	0-100 mg/dL
Calculated		
Non-HDL Cholesterol	204	<130 mg/dL
Calculated		
LDL / HDL Cholesterol Ratio	3.76	0.00-3.55 Ratio
Calculated		
Total / HDL Cholesterol Ratio	5.49	0.00-4.97 Ratio
Calculated		

Equipment Used: Cobas c303 Biochemistry Analyzer Integrated System

Equipment measurement : Colorimetric/Rate,Potentiometric (Direct ISEs),Immuno-rate,Turbidimetric,Enhanced Chemiluminescence

COMMENT :

Tests results are created by fully/semi automated equipments.

This is only a professional opinion, not the diagnosis.

Please correlate with clinical conditions and drug history.

This report is not valid for medico legal purpose.

If the results of the tests are alarming or unexpected, please contact immediately.

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		
Referred By	: NA		MDR-LYK
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:41PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

ImmunoAssay

Test Description	Observed Value	Biological Reference Interval
Vitamin B12 (Cyanocobalamin)Serum		
Vitamin B12 CLIA	222.0	211-911 pg/mL
Comments Vitamin B ₁₂ along with folate is essential for DNA synthesis and myelin formation. Vitamin B ₁₂ deficiency can be because of nutritional deficiency, malabsorption and other gastrointestinal causes. The test is ordered primarily to help diagnose the cause of macrocytic/ megaloblastic anemia.		
Decreased levels are seen in:		Increased levels are seen in:
anaemia, normal near term pregnancy, vegetarianism, partial gastrectomy/ ileal damage, celiac disease, with oral contraceptive use, parasitic competition, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advancing age		renal failure, hepatocellular disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		
Referred By	: NA		MDR-LYK
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:35PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
Vitamin D 25-Hydroxy (VIT-D) Serum		
Vitamin D, 25 Hydroxy Chemiluminescent Immunoassay (CLIA)	46.2	30-100 ng/mL
Comments The test is useful for diagnosis of vitamin D deficiency, hypervitaminosis D, differential diagnosis of causes of rickets and osteomalacia and monitoring vitamin D replacement therapy. Vitamin D is a generic designation for a group of fat-soluble, structurally similar sterols, which act as hormones. Vitamin D compounds in the body are exogenously derived by dietary means; from plants as 25-hydroxyvitamin D2 (ergocalciferol or calciferol) or from animal products as 25-hydroxyvitamin D3 (cholecalciferol or calcidiol). Vitamin D may also be endogenously derived by conversion of 7-dihydrocholesterol to 25-hydroxyvitamin D3 in the skin upon ultraviolet exposure.		
Reference Range Deficiency < 20 ng/mL Insufficiency 20-30 ng/mL Sufficiency 30-100 ng/mL Toxicity >100 ng/mL		
Interpretation 25-OH-VitD levels below 25 ng/mL are associated with an increased risk of secondary hyperparathyroidism, reduced bone mineral density, and fractures, particularly in the elderly. Intervention studies support this clinical cutoff, showing a reduction of fracture risk with 25-OH-VitD replacement. Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry. In patients where testing is not completely consistent with the suspected diagnosis, in particular, if serum 25-OH-VitD levels are >10 ng/mL, an alternative cause for impaired mineralization should be considered. Possible differential diagnosis includes: partly treated vitamin D deficiency, extremely poor calcium intake, vitamin D resistant rickets, renal failure, renal tubular mineral loss with or without renal tubular acidosis, hypophosphatemic disorders (eg, X-linked or autosomal dominant hypophosphatemic rickets), congenital hypoparathyroidism, activating calcium sensing receptor mutations, and osteopetrosis. Measurement of serum urea, creatinine, magnesium, and 1,25-dihydroxyvitamin D (DHVD) is recommended as a minimal additional workup for these patients. Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25-OH-VitD, as can occur in granulomatous diseases, particular sarcoid, or from nutritionally-induced hypervitaminosis D. Serum 1,25-OH-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of greater than 80 ng/mL, typically greater than 150 ng/mL.		
Cautions Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid. Newer antiseizure medications have not been studied or are not thought to contribute to vitamin D deficiency.		

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		
Referred By	: NA		MDR-LYK
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 03:59PM	Approved Date	:13-Oct-2026 04:35PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Test Description	Observed Value	Biological Reference Interval
T3 T4 TSH, Serum		
Triiodothyronine_Total (T3) Chemiluminescence Immunoassay (CLIA)	107	60-181 ng/dL
Thyroxine_Total (T4) Chemiluminescence Immunoassay (CLIA)	8.2	4.8-10.4 ug/dL
3rd Gen. (TSH Ultrasensitive),Serum Chemiluminescence Immunoassay (CLIA)	2.20	0.35-5.50 uIU/mL

COMMENT :

The levels of thyroid hormone (T3 & T4) Are Low In case of Primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also. Increased levels are found in grave's disease, hyperthyroidism and thyroid hormone resistance. T3 levels are also raised in T3 thyrotoxicosis. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.

In Pregnancy:

Level	Total T3	Total T4	TSH
Ist Trimester	81-190 ng/dL	6.6-12.4 ug/dL	0.1-2.5 uIU/mL
IInd Trimester	100-260 ng/dL	6.6-15.5 ug/dL	0.2-3.0 uIU/mL
IIIrd Trimester	100-260 ng/dL	6.6-15.5 ug/dL	0.3-3.0 uIU/mL

*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460

DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484



Laboratory is NABL Accredited



Reference No.	: - 2610009213	Age/Gender	: 44 Yrs/Male
Pt's Name	: Mr. SANJEEV CHAUDHARY		MDR-LYK
Referred By	: NA		
Sample Collection Date/Time	: 13-Oct-2026	Date	:13-Oct-2026
Sample Receiving Date/Time	: 13-Oct-2026 04:22PM	Approved Date	:13-Oct-2026 05:17PM
Sample From	: MDR-LYKA PATHOLOGY CLINIC	Report Print Time	:13-Oct-2026 06:04PM

Microscope

Test Description	Observed Value	Biological Reference Interval
URINE EXAMINATION ROUTINE		
Physical Examination		
Volume	20.00	- mL
Colour	PALE YELLOW	
Appearance	CLEAR	Clear
pH	6.00	
Double Indicators Test		
Specific Gravity	1.025	1.005-1.030
Refractometric		
Chemical Examination		
Urine Protein	NIL	Negative
Protein Indicator		
Urine Sugar	NIL	Negative
Oxidation Reaction		
Microscopic Examination		
R.B.C.	NIL	NIL /HPF
Microscopy		
Pus Cells	1-2	0-5 /HPF
Microscopy		
Epithelial Cells	1-2	0-3 /HPF
Microscopy		
Casts	NIL	Nil /LPF
Microscopy		
Crystals	NIL	Nil
Microscopy		
Bacteria	NIL	Nil
Microscopy		

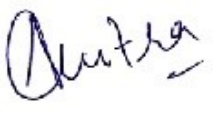
*** End Of Report ***



Dr. Pooja Devi
PhD, Biochemistry
Authorized Signatory

Dr. Aditi Gupta
MBBS M.D (Pathology)
Reg. No 5755

Dr. Sonal Agarwal
MBBS M.D (Microbiology)
Reg. No 28460


DR. Chitra Chauhan
MBBS M.D (Pathology)
Reg. No 90484