



Name :	DUMMY	Age :	25 Years
Lab No. :	WM130N01	Gender :	Male
Ref By :	DR. DUMMY DUMMY	Reported :	19/4/2025 10:29:38AM
Collected :	18/4/2025 12:16:00PM	Report Status :	Interim
A/c Status :	P	Processed at :	LPL-NATIONAL REFERENCE LAB
Collected at :	PRODUCTION TEST COLLECTION CENTRE		
	SECTOR - 18, BLOCK-E ROHINI		
	DELHI 110085		
	National Reference laboratory, Block E, Sector 18, Rohini, New Delhi -110085		

Test Report

Test Name	Results	Units	Bio. Ref. Interval
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SWASTHFIT PREMIUM MALE

LIPID PROFILE COMPLETE

Cholesterol Total (CHO-POD)		mg/dL	<200
Triglycerides (GPO-POD)		mg/dL	<150
HDL Cholesterol (Enz Immunoinhibition)		mg/dL	>40
LDL Cholesterol, Direct (enz Selective protection)		mg/dL	<100
VLDL Cholesterol (Calculated)		mg/dL	<30
Non-HDL Cholesterol (Calculated)		mg/dL	<130
Cholesterol: HDL Ratio			3.30 - 4.40
Apolipoprotein (Apo A1) (Immunoturbidimetry)		mg/dL	79 - 169
Apolipoprotein (Apo B) (Immunoturbidimetry)		mg/dL	46 - 174
Apo B / Apo A1 Ratio (Calculated)			0.35 - 0.98
Lipoprotein(a); Lp(a) (Immunoturbidimetry)		mg/dL	<20
HsCRP (Immunoturbidimetry)		mg/L	<1.00
Homocysteine (CMIA)		umol/L	5.46 - 16.20

Note

1. Test conducted in serum.
2. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
3. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
4. If initial HsCRP > 10mg/L, it should be disregarded & measured again when patient stabilizes. Avoid measurement during acute infection, chronic inflammatory disease, post menopausal hormone therapy.



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5. If initial HsCRP<10mg/L - use average of two values (measured 2 or more weeks apart; intra-individual variation being >40%) to estimate risk			

REMARKS	CHOLESTEROL : HDL RATIO	HsCRP in (mg/L)	Lp (a) (dL)
Low risk	3.3-4.4	<1.0	<20
Average risk	4.5-7.1	-	-
Moderate risk	7.2-11.0	1.0-3.0	30-49
High risk	>11.0	>3.0	>50

Treatment Goals as per Lipid Association of India 2019

ASCVD RISK CATEGORY@	CONSIDER THERAPY		TREATMENT GOAL		
	LDL CHOLESTEROL (LDL-C) (mg/dL)	NON HDL CHOLESTEROL (NON HDL-C) (mg/dL)	LDL CHOLESTEROL (LDL-C) (mg/dL)	NON HDL CHOLESTEROL (NON HDL-C)	APOLIPOPROTEIN B (Apo B) mg/dL
Extreme (A)	>=50	>=30	<50 (Indispensable) <30 (Optional)	<80	<65
Extreme (B)	>=30	>=60	<30	<60	<50
Very High	>=50	>=80	<50	<80	<65
High	>=70	>=100	<70	<100	<80
Moderate	>=100	>=130	<100	<130	-
Low	>=130*	>=160*	<100	<130	-

* In low risk patient consider therapy after an initial non-pharmacological intervention for at least 3 months

To know your risk category click on bit.ly link sent on your registered mobile number, answer the questionnaire, the ASCVD risk report can be downloaded from website

Comments

The NCEP ATP III guidelines established LDL-C & Non LDL-C treatment goals in 2004 since then use of lipid lowering drugs particularly statins has reduced Atherosclerotic Cardiovascular disease (ASCVD) morbidity and mortality; however significant residual risk for the events remains. This combined with the rising prevalence of



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obesity, which has shifted the risk profile of the population toward patients in whom LDL -C is less predictive of ASCVD events (metabolic syndrome, low HDL Cholesterol, elevated triglycerides). In addition, testing for inflammatory (HsCRP), non-lipid (Homocysteine) and other lipid biomarkers (Apo A, Apo B, Lp(a)) may be considered for risk refinement. The presence of one or more secondary risk factors should prompt the clinician to consider drug therapy for patient whose atherogenic cholesterol level is higher than goal level.			

Apolipoprotein B:

Apo B concentration measures the number of all atherogenic particles [apo B concentration = apo B in chylomicron + apo B in VLDL + apo B in VLDL remnant + apo in IDL + apo in LDL+ apo B in Lp(a)]. Apo B is moderate non-conventional risk factor. A level ≥ 110 mg/dl of apo B corresponds to an LDL-C ≥ 130 mg/dl) in low and moderate risk groups. Apo B measurement is recommended in high-risk subjects, after LDL-C and non-HDL-C goals have been achieved. Discordant elevated apo B levels may identify individuals who have high residual cholesterol risk. This may warrant intensive statin therapy and use of non-statin drugs.

To assess ASCVD risk, It is preferable to estimate serum apo B in patients with Diabetes, metabolic syndrome, obesity, high triglyceride concentration and very low LDL-C levels

Lipoprotein (a); Lp(a):

Lp(a) is an independent risk factor for coronary heart disease (CHD), ischemic stroke, and aortic valve stenosis and has been referred to as "the most atherogenic lipoprotein". It appears to be very important ASCVD risk factor for Indians as Indians tend to have high prevalence of elevated Lp(a). In Indians, Lp(a) measurement is strongly recommended under following conditions:

1. At the time of initial screening of all subjects (18 years of age in adults and at the age of 2 years in subjects with family history of FH and premature ASCVD)
2. In patients with:
 - Premature ASCVD (<55 years in men, <65 years in women)
 - Familial hypercholesterolemia
 - Family history of premature CVD and/or elevated Lp(a)
 - Recurrent ASCVD despite optimal lipid lowering treatment
3. In patients showing poor response to maximum lipid lowering therapy

Homocysteine:

There is an association between elevated levels of circulating homocysteine and various vascular and cardiovascular disorders. Clinically the measurement of homocysteine is considered important to assess risk factor for cardiovascular disease (CVD) for which the recommendations are:



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- Specially useful in young CVD patients (< 40 yrs) - In known cases of CVD, high homocysteine levels should be used as a prognostic marker for CVD events and mortality - CVD patients with homocysteine levels > 15 umol/L belong to a high risk group			

HsCRP:

Elevated CRP levels is a risk factor for ASCVD that is independent of patient's LDL value. HsCRP is a strong indicator of future cardiovascular events. Patients with elevated CRP levels may have greater benefit in risk reduction with statin therapy than those with lower CRP levels independent of LDL cholesterol values.

LIVER & KIDNEY PANEL, SERUM

Creatinine (Modified Jaffe,Kinetic)	mg/dL	0.70 - 1.30
GFR Estimated (CKD EPI Equation 2021)	mL/min/1.73m2	>59
GFR Category (KDIGO Guideline 2012)		
Urea (Urease UV)	mg/dL	13.00 - 43.00
Urea Nitrogen Blood (Calculated)	mg/dL	6.00 - 20.00
BUN/Creatinine Ratio (Calculated)		
Uric Acid (Uricase)	mg/dL	3.50 - 7.20
AST (IOT) (IFCC without P5P)	U/L	15.00 - 40.00
ALT (SGPT) (IFCC without P5P)	U/L	10.00 - 49.00
AST:ALT Ratio (Calculated)		<1.00
GGTP (IFCC)	U/L	0 - 73



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Alkaline Phosphatase (ALP) (IFCC-AMP)		U/L	30.00 - 100.00
Bilirubin Total (Oxidation)		mg/dL	0.30 - 1.20
Bilirubin Direct (Oxidation)		mg/dL	<0.3
Bilirubin Indirect (Calculated)		mg/dL	<1.10
Total Protein (Biuret)		g/dL	5.70 - 8.20
Albumin (BCG)		g/dL	3.20 - 4.80
Globulin(Calculated)		gm/dL	2.0 - 3.5
A : G Ratio (Calculated)			0.90 - 2.00
Calcium, Total (Arsenazo III)		mg/dL	8.70 - 10.40
Phosphorus (Molybdate UV)		mg/dL	2.40 - 5.10
Sodium (Indirect ISE)		mEq/L	136.00 - 145.00
Potassium (Indirect ISE)		mEq/L	3.50 - 5.10
Chloride (Indirect ISE)		mEq/L	98.00 - 107.00

Note

- Estimated GFR (eGFR) calculated using the 2021 CKD-EPI creatinine equation and GFR Category reported as per KDIGO guideline 2012.
- GFR Category G1 or G2 does not fulfil the criteria for CKD, in the absence of evidence of kidney damage.
- The BUN/Creatinine ratio is used to differentiate prerenal and postrenal azotemia from renal azotemia. Because of considerable variability, it should be used only as a rough guide. Normally, the BUN/creatinine ratio is about 10:1



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Test Report

Test Name	Results	Units	Ref. Interval
CK; CREATINE KINASE, SERUM (IFCC)			
CK		U/L	46.00 - 171.00

Comments

CPK is an enzyme found primarily in skeletal and cardiac muscle. It is elevated in diseases like Muscular dystrophy, Myopathies, Polymyositis, Muscle trauma, Myocardial infarction, Cardiac catheterization, Electrical cardioversion, Hypothyroidism, Stroke and also following intramuscular injections. Drugs, infections and diseases leading to injury or inflammation of muscles releases CPK into the circulation. Normal levels are seen in Neurogenic muscle diseases like Multiple Sclerosis, Amyotrophic lateral sclerosis and Parkinsonism. Isoenzyme studies are advised in patients with elevated levels.

SUGAR CHOICE, PLASMA (Hexokinase)			
Glucose, Fasting		mg/dL	70.00 - 100.00

MICROALBUMIN/ALBUMIN RATIO (MOR) - FIRST MORNING/RANDOM URINE			
Albumin, Urine (Immunoturbidimetry)		mg/L	<30
Creatinine, Urine (Modified Jaffe, DM5000, traceable)		mg/dL	24.00 - 392.00
Albumin: Creatinine Ratio (ACR) (Calculated)		mg/g creatinine	<30.00
ACR Category			

- Due to high biological variability and non-renal influences, ACR>30 mg/g creatinine in a random urine sample should be confirmed with a subsequent early morning urine sample or 24 hours urine sample.
- The diagnosis of albuminuria requires the demonstration of increased albumin loss (either increased albumin creatinine ratio or albumin loss in 24 hrs urine sample) in at least two out of three urine samples.



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specimens collected in the absence of infection or acute metabolic crisis.			
3. The term Microalbuminuria is misleading as it implies a small version of albumin molecule rather than an excretion rate of albumin greater than normal but less than that detected by routine methods. It is recommended to use term Albuminuria or Albumin Creatinine ratio (ACR) instead of Microalbuminuria.			

Non-Renal causes of increased ACR

Menstrual contamination, Uncontrolled Hypertension, Urinary Tract Infection, Heart failure, Strenuous exercise and other transitory illnesses.

PSA (PROSTATE SPECIFIC ANTIGEN), TOTAL, SERUM (CMIA)

PSA, TOTAL	ng/mL	<4.00
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TESTOSTERONE, TOTAL, SERUM (CLIA)

Testosterone, Total	ng/dL	164.94 - 753.38
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THYROID PROFILE, FREE, SERUM (CLIA)

Free Triiodothyronine (FT3 Free)	pg/mL	2.30 - 4.20
Free Thyroxine (FT4 Free)	ng/dL	0.89 - 1.76
TSH, Ultrasensitive	µIU/mL	0.550 - 4.780

Note

- TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm. The variation is of the order of 50%. hence time of the day has influence on the measured serum TSH concentrations.
- TSH Values <0.03 µIU/mL need to be clinically correlated due to presence of a rare TSH variant in



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**Test Report**

Test Name	Results	Units	Ref. Interval
some individuals			



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Test Report

Test Name	Results	Units	Bio. Ref. Interval
IRON STUDIES MONITORING PANEL (Spectrophotometry, CLIA)			
Iron	34.00	µg/dL	65.00 - 175.00
Total Iron Binding Capacity (TIBC)	90.00	µg/dL	250.00 - 425.00
Transferrin Saturation	37.78		20.00 - 50.00

Comment

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron, leads to microcytic hypochromic anemia. The toxic effects of iron are deposition of iron in various organs of the body and hemochromatosis.

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. In iron deficiency anemia, serum iron is reduced and TIBC increases.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

Ferritin appears to be in equilibrium with tissue ferritin and is a good indicator of storage iron in normal subjects and in most disorders. In patients with some hepatocellular diseases, malignancies and inflammatory diseases, serum ferritin is a disproportionately high estimate of storage iron because serum ferritin is an acute phase reactant. In such disorders iron deficiency anemia may exist with a normal serum ferritin concentration. In the presence of inflammation, persons with low serum ferritin are likely to respond to iron therapy.



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Test Report

Test Name	Results	Units	Bio. Ref. Interval
HEMOGRAM			
Hemoglobin (Photometry)		g/dL	13.00 - 17.00
Packed Cell Volume (PCV) (Calculated)		%	40.00 - 50.00
RBC Count (Electrical impedance)		mill/mm ³	4.50 - 5.50
MCV (Electrical impedance)		fL	83.00 - 101.00
Mentzer Index (Calculated)			
MCH (Calculated)		pg	27.00 - 32.00
MCHC (Calculated)		g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW) (Electrical Impedance)		%	11.60 - 14.00
Total Leukocyte Count (TLC) (Electrical Impedance)		thou/mm ³	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils (VCS Technology)		%	40.00 - 80.00
Lymphocytes (VCS Technology)		%	20.00 - 40.00
Monocytes (VCS Technology)		%	2.00 - 10.00
Eosinophils (VCS Technology)		%	1.00 - 6.00
Basophils (VCS Technology)		%	<2.00
Metamyelocytes (VCS Technology)		%	
Myelocytes (VCS Technology)		%	
Probandocytes (VCS Technology)		%	
Blasts (VCS Technology)		%	
Absolute Leucocyte Count			



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Neutrophils (Calculated)		thou/mm ³	2.00 - 7.00
Lymphocytes (Calculated)		thou/mm ³	1.00 - 3.00
Monocytes (Calculated)		thou/mm ³	0.20 - 1.00
Eosinophils (Calculated)		thou/mm ³	0.02 - 0.50
Basophils (Calculated)		thou/mm ³	0.02 - 0.10
Others (Calculated)			
Platelet Count (Electrical impedance)		thou/mm ³	150.00 - 410.00
Mean Platelet Volume (Electrical impedance)		fL	6.5 - 12.0
E.S.R. (Capillary photometry)		mm/hr	0.00 - 15.00



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MAGNESIUM, SERUM (Xylidyl blue)		mg/dL	1.60 - 2.00
IMMUNOGLOBULIN IgE, SERUM (FEIA)		kUA/L	64.00
CORTISOL, MORNING, SERUM (CLIA)		µg/dL	3.70 - 19.40

Note: Cortisol is best measured in the morning when evaluating for possible Adrenal insufficiency and best measured in the afternoon or evening to differentiate normal and Cushing's Syndrome subjects. Diurnal rhythmicity of cortisol is increased by systemic disease and stress.

Clinical Use

* Direct assessment of Adrenal function

Increased levels: Cushing's Syndrome, Ectopic ACTH syndrome, Ectopic CRH syndrome, Adrenal adenoma / carcinoma, Adrenal micronodular dysplasia, Adrenal macronodular hyperplasia, Stress

Decreased Levels - Addisons disease, Pituitary dysfunction

AMYLASE, SERUM (G7PNP)	U/L	30.00 - 118.00
AFP (ALPHA FETOPROTEIN, TUMOR MARKER, SERUM) (CMIA)	ng/mL	<10.00

Note

1. This test is not recommended to screen cancers in the general population.
2. False negative/positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.
3. Use of AFP as a tumor marker is not recommended in pregnant females.
4. AFP values regardless of levels should not be interpreted as absolute evidence for the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations.
5. The concentration of AFP in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity



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Clinical Use

- Useful for determining prognosis and monitoring therapy for Hepatocellular carcinoma. Level of AFP is a prognostic indicator of survival. Elevated AFP and serum bilirubin levels in these patients is associated with shorter survival time.
- An aid in the management of Germ cell (Non-Seminomatous) tumors. Measurement of AFP levels in combination with HCG levels are useful in classifying and staging Germ cell tumors
- To predict tumor recurrence/presence of residual tumor

Increased Levels

- Germ cell (Non-Seminomatous) tumors
- Primary hepatocellular carcinoma (70%)
- Teratocarcinoma
- Gastrointestinal tract cancers with or without liver metastasis
- Benign hepatic conditions like Acute Viral Hepatitis, Chronic active hepatitis and Cirrhosis
- Ataxia telangiectasia
- Hereditary tyrosinemia

CEA; CARCINO EMBRYONIC ANTIGEN SERUM (CMIA)	ng/mL	<3.00
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Interpretation

REFERENCE GROUP	REFERENCE RANGE IN ng/mL
Non Smokers	< 3.00
Smokers	< 5.00

Note

- This test is not recommended for cancer screening in the general population.
- False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.
- Patients with confirmed carcinoma may show normal pre-treatment CEA levels. Hence this assay, regardless of level, should not be interpreted as absolute evidence for presence or absence of malignant disease. The assay value should be used in conjunction with findings from clinical evaluation and other diagnostic procedures.
- Persistently elevated CEA levels are usually indicative of progressive malignant disease and poor therapeutic response.
- The concentration of CEA in a given specimen, determined with assays from different manufacturers,



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Clinical Use

- Monitoring patients with Colorectal, Gastrointestinal, Lung & Breast carcinoma
- Diagnosis of occult metastatic disease and / or residual disease

DISEASE	PERCENTAGE POSITIVITY	CEA
Colorectal cancer	70	
Lung cancer	45	
Gastric cancer	50	
Breast cancer	40	
Pancreatic cancer	5	
Ovarian cancer	1	
Uterine cancer	40	
Cirrhosis		
Pulmonary emphysema	30	
Rectal polyps	5	
Benign breast disease	15	
Ulcerative colitis	15	

C-REACTIVE PROTEIN; CRP, SERUM (Immunoturbidimetry)	mg/L	<3.30
FOLATE (FOLIC ACID), SERUM (CLIA)	ng/mL	>5.38
HEPATITIS B SURFACE ANTIGEN; HBsAg, SERUM (CMIA)		Non Reactive



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HEPATITIS C ANTIBODY (Anti-HCV), SERUM (CMIA)		Index	<1.0
LIPASE, SERUM (Spectrophotometry)		U/L	2.00 - 53.00

Comments

Pancreas is the major and primary source of serum lipase though lipase is also present in liver, stomach, intestine, WBC, fat cells and milk. In acute pancreatitis, serum lipase becomes elevated at the same time as amylase and remains high for 7-10 days. Increased lipase activity rarely lasts longer than 14 days. Prolonged increase suggests poor prognosis or presence of a cyst. The simultaneous rise of serum lipase and serum amylase is effective in ruling out acute pancreatitis.

Increased levels

- Acute & Chronic pancreatitis.
- Obstruction of pancreatic duct.
- Non pancreatic conditions like renal disease, acute cholecystitis, intestinal obstruction, duodenal ulcer, alcoholism, diabetic ketoacidosis and following endoscopic retrograde cholangiopancreatography.

RHEUMATOID FACTOR (RA), SERUM (Immunoturbidimetry)	IU/mL	<14.00
VITAMIN B12; CYANOCOBALAMIN, SERUM (CLIA)	pg/mL	211.00 - 911.00
VITAMIN D, 25 - HYDROXY, SERUM (CLIA)	nmol/L	75.00 - 250.00





Name :	DUMMY	Age :	25 Years
Lab No. :	WM130N01	Gender :	Male
Ref By :	DR. DUMMY DUMMY	Reported :	19/4/2025 10:29:52AM
Collected :	18/4/2025 12:16:00PM	Report Status :	Interim
A/c Status :	P	Processed at :	LPL-NATIONAL REFERENCE LAB
Collected at :	PRODUCTION TEST COLLECTION CENTRE		National Reference laboratory, Block E, Sector 18, Rohini, New Delhi -110085
	SECTOR - 18, BLOCK-E ROHINI		
	DELHI 110085		

Test Report

Test Name	Results	Units	Ref. Interval
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URINE EXAMINATION, ROUTINE; URINE R/E, AUTOMATED

Gross Examination

Colour (Automated strip test)	Light Yellow
Specific gravity (Pre-treated polymeric Ion Exchange resin)	1.000 -1.030
Ph (Double Indicator)	5.0 - 8.0
Proteins (Tetra bromphenol blue)	Negative
Glucose (Glucose oxidase)	Negative
Ketones (Sodium nitroprusside)	Negative
Bilirubin (Diazonium salt)	Negative
Urobilinogen (Diazonium salt)	Normal
Blood (Tetramethyl benzidine)	Negative
Leukocyte esterase (Carboxylic acid ester diazonium salt)	Negative
Nitrite (Sulfanic acid Tetrahydrobenzol)	Negative
Ascorbic Acid (Indophenol)	Negative

Microscopy

RBC	/hpf	0.0 - 2.0
Pus cells	/hpf	0.0 - 5.0
Epithelial cells	/hpf	0.0 - 5.0
Calcium oxalate monohydrate crystals	/hpf	0.0 - 0.99
Calcium oxalate dihydrate crystals	/hpf	0.0 - 0.99





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**SECTOR - 18, BLOCK-E ROHINI
 DELHI 110085**

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Gender : Male
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Test Report

Test Name	Results	Units	Ref. Interval
Triple Phosphate crystals		/hpf	0 - 0.99
Uric acid crystals		/hpf	0 - 0.99
Calcium Phosphate		/hpf	0.0 - 0.99
Cystine crystals		/hpf	0.0 - 0.99
Leucine crystals		/hpf	0.0 - 0.99
Tyrosine crystals		/hpf	0.0 - 0.99
Amorphous urates crystals		/hpf	0.0 - 0.99
Amorphous phosphate crystals		/hpf	0.0 - 0.99
Hyaline casts		/hpf	0.0 - 5.0
Hyaline-Granular casts		/hpf	0.0 - 0.99
Granular casts		/hpf	0.0 - 0.99
RBC casts		/hpf	0.0 - 0.99
WBC casts		/hpf	0.0 - 0.99
Fatty casts		/hpf	0.0 - 0.99
Waxy casts		/hpf	0.0 - 0.99
Microorganism Casts		/hpf	0.0 - 0.99
Yeast cells		/hpf	0.0 - 1.0
Capsula Rod		/hpf	0.0 - 80.0
Bacteria cocci		/hpf	0.0 - 80.0
Mucus		/hpf	0.0 - 80.0





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DELHI 110085

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Test Report

Test Name	Results	Units	Ref. Interval
Others		/hpf	



Name : DUMMY
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 SECTOR - 18, BLOCK-E ROHINI
 DELHI 110085

Age : 25 Years
Gender : Male
Reported : 19/4/2025 10:29:55AM
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Test Report

Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC,NGSP Certified)			
HbA1c	5.0	%	4.00 - 5.60
Estimated average glucose (eAG)	97	mg/dL	

Interpretation as per American Diabetes Association (ADA) Guidelines

Reference Group	Non diabetic adults ≥ 18 years	At risk (Prediabetes)	Diagnosing Diabetes	Therapeutic goals for glycemic control
HbA1c in %	4.0-5.6	5.7-6.4	≥ 6.5	< 7.0

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1C result does not correlate with the patient's blood glucose levels.

FACTORS THAT INTERFERE WITH HbA1C MEASUREMENT	FACTORS THAT AFFECT INTERPRETATION OF HbA1C RESULTS
Hemoglobin variants, elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements	Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g., recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used. Iron deficiency anemia is associated with higher HbA1c



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Test Report

Test Name	Results	Units	Bio. Ref. Interval
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Dr Ajay Gupta
MD, Pathology
Technical Director - Hematology & Immunology
NRL - Dr Lal PathLabs Ltd

Dr.Anirudh Bharat Kumar Gupta
MD, Microbiology
Senior Consultant Microbiologist
NRL - Dr Lal PathLabs Ltd

Dr Anjalika Goyal
MD,Biochemistry
Consultant Biochemist
NRL - Dr Lal PathLabs Ltd

Dr. Mangshu Kumar
MD, Biochemistry
Sr. Consultant Biochemist
NRL - Dr Lal PathLabs Ltd

Dr Nimmi Kansal
MD, Biochemistry
Technical Director - Clinical Chemistry & Biochemical Genetics
NRL - Dr Lal PathLabs Ltd

Dr Puneeta Singh
Ph.D (Microbiology)
Principal Research Scientist
NRL - Dr Lal PathLabs Ltd

Dr Sarita Chhabri Lal
MD, Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

Dr Shalabh Malik
MD, Microbiology
Technical Director - Microbiology, Infectious Disease Molecular & Serology, Clinical Pathology
NRL - Dr Lal PathLabs Ltd

Dr.Richa Sirohi
MD, Biochemistry
Sr. Consultant Biochemist
NRL - Dr Lal PathLabs Ltd

Dr Sumit
MD, Pathology
Sr. Consultant Pathologist - Hematology & Immunology
NRL - Dr Lal PathLabs Ltd

Follow up.

LIPID PROFILE COMPLETE, CK; CREATINE KINASE, SERUM, IRON STUDIES MONITORING PANEL, HEMOGRAM, SUGAR CHOICE, PLASMA, LIVER & KIDNEY PANEL, SERUM, MAGNESIUM, SERUM, IMMUNOGLOBULIN IgE, SERUM, URINE EXAMINATION, ROUTINE; URINE R/E, AUTOMATED, MICROALBUMIN/ALBUMIN, 1ST MORNING/ RANDOM URINE, HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD, CORTISOL, MORNING, SERUM, AMYLASE, SERUM, AFP (ALPHA FETOPROTEIN), TUMOR MARKER, SERUM, CEA; CARCINO EMBRYONIC ANTIGEN, SERUM, C-REACTIVE PROTEIN; CRP, SERUM, FOLATE (FOLIC ACID), SERUM, HEPATITIS B SURFACE ANTIGEN; HBsAg, SERUM, HEPATITIS C ANTIBODY (Anti-HCV), SERUM, LIPASE, SERUM, PSA (PROSTATE SPECIFIC ANTIGEN), TOTAL, SERUM, RHEUMATOID FACTOR (RA), SERUM, TESTOSTERONE, TOTAL, SERUM, THYROID PROFILE, FREE, SERUM, VITAMIN B12; CYANOCOBALAMIN, SERUM, VITAMIN D, 25 - HYDROXY, SERUM



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Test Report

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IMPORTANT INSTRUCTIONS

•Test results released pertain to the specimen submitted. •All test results are dependent on the quality of the sample received by the Laboratory .
•Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the Referring Physician .•Report delivery may be delayed due to unforeseen circumstances. Inconvenience is regretted .•Certain tests may require further testing at additional cost for derivation of exact value. Kindly submit request within 72 hours post-report .•Test results may show interlaboratory variations. •The Courts/Forum at Delhi shall have exclusive jurisdiction in all disputes/claims concerning the test(s) and results of test(s). •Test results are not valid for medico legal purposes. •This is computer generated medical diagnostic report that has been validated by Authorized Medical Practitioner/Doctor. •The report does not need physical signature.

(#) Sample drawn from outside source.

If Test results are alarming or unexpected, client is advised to contact the Customer Care immediately for possible remedial action.

Tel: +91-11-49885050, Fax: - +91-11-2788-2134, E-mail: lalpathlabs@lalpathlabs.com

National Reference lab, Delhi, a CAP (7171001) Accredited, ISO 9001:2015 (FS60411) & ISO 27001:2013 (616691) Certified laboratory.

