

**Laboratory Investigation Report**

Patient Name	Centre
Age/Gender	OP/IP No/UHID
MaxID/Lab ID	Collection Date/Time
Ref Doctor	Reporting Date/Time

**Immunoassay****Extensive Thyroid Profile**

SIN No: DN1266781

**Vitamin D, 25 - Hydroxy Test (Vit. D3)\*, Serum**

Date	01/Jun/2024 24/May/24	Unit	Bio Ref Interval
	09:57AM 02:56PM		
25 Hydroxy, Vitamin D CLIA	31.34 13.71	ng/mL	30-100

**Ref Range**

Vitamin D Status	25 (OH) Vitamin D Concentration Range (ng/ml)
Sufficiency	30-100
Insufficiency	20-29
Deficiency	<20
Potential Toxicity	>100

**Interpretation**

Vitamin D toxicity can be due to

1. Use of high doses of vitamin D for prophylaxis or treatment
2. Taking vitamin D supplements with existing health problems such as kidney disease, liver disease, tuberculosis and hyperparathyroidism

Vitamin D deficiency can be due to:

1. Inadequate exposure to sunlight,
2. Diet deficient in vitamin D
3. Malabsorption

**Advice:** Serum calcium, phosphorus and PTH

Kindly correlate with clinical findings

**\*\*\* End Of Report \*\*\***  
**Dr. Mini Singhal M.D.**  
Principal Consultant Pathology  
**Dr. Shalini Shah M.D.**  
Attending Consultant Pathology

Test Performed at : 1108 - Max Hospital Dehradun, Near Indian Oil Petrol Pump, Malsi, Mussoorie Diversion Road, Dehradun

Booking Centre : 1108 - Max Hospital Dehradun, Near Indian Oil Petrol Pump, Malsi, Mussoorie Diversion Road, Dehradun, 1356673000

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**Serology Special**
**Extensive Thyroid Profile**


SIN No:DN1266781

Test Name	Result	Unit	Bio Ref Interval
<b>Anti Thyroid Anti Body Panel,Serum</b>			
CLIA			
Thyroglobulin Antibody(TG)	20.89	IU/mL	5 - 100
Thyroid Peroxidase Antibody (TPO)	<b>63.60</b>	IU/mL	1 -16
CLIA			

Kindly correlate with clinical findings

\*\*\* End Of Report \*\*\*



**Dr. Poonam S. Das, M.D.**  
Principal Director-  
Max Lab & Blood Bank Services



**Dr. Bansidhar Tarai, M.D.**  
Associate Director  
Microbiology & Molecular Diagnostics



**Dr. Sonu Kumari Aggrawal, MD**  
Consultant Microbiology



**Dr. Nidhi Malik, MD**  
Consultant Microbiology

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MC-2714

**Laboratory Investigation Report**

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**Clinical Biochemistry**

**Extensive Thyroid Profile**
**Fasting Blood Sugar (Glucose) , (FBS)\*, Fluoride Plasma**

Date	01/Jun/2024	Unit	Bio Ref Interval
	09:57AM		
Glucose (Fasting)	98	mg/dl	74 - 99
Hexokinase			

**Calcium, Serum\***

Date	01/Jun/2024	09/Apr/24	Unit	Bio Ref Interval
	09:57AM	12:05PM		
Calcium (Total)	9.53	9.65	mg/dl	8.8 - 10.2
Arsenazo III				

**Comment**

Increased in Primary and Tertiary hyperparathyroidism, malignant disease with bone involvement, Polycythemia vera, pheochromocytoma and Sarcoidosis.

Advise: PTH testing. If normal or increased, then check urine  $Ca^{++}$ /Creatinine ratio to exclude Familial benign hypocalciuric hypercalcemia (FBHH)

Decreased in surgical or congenital hyperparathyroidism; Vitamin D deficiency, chronic renal failure; magnesium deficiency, prolonged anticonvulsant therapy, acute pancreatitis, hyperphosphatemia, massive blood transfusion, leprosy, proximal and distal renal tubular disease, alcoholism and hepatic cirrhosis.


**Advice:** Albumin, Phosphate, Creatinine, Alkaline Phosphatase and PTH.

Kindly correlate with clinical findings

\*\*\* End Of Report \*\*\*



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Principal Consultant Pathology



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**Immunoassay**

**Extensive Thyroid Profile**
**Folate , Serum\***

<b>Date</b>	<b>01/Jun/2024</b>	<b>Unit</b>	<b>Bio Ref</b>
	<b>09:57AM</b>		<b>Interval</b>
Folate Serum	18.2	ng/mL	>5.9
CLIA			

**Ref Range**

Folate (Normal)	>5.9
Folate (Indeterminate)	4.0 - 5.9
Folate (Deficient)	<4.0

**Interpretation**

A folate deficiency can lead to megaloblastic anemia and ultimately to severe neurological problems. Folate deficiency can be caused by insufficient dietary intake, malabsorption or excessive folate utilization, which is common during pregnancy, alcoholism, hepatitis, or other liver-damaging diseases.

**Free T3,Serum\***

<b>Date</b>	<b>01/Jun/2024</b>	<b>Unit</b>	<b>Bio Ref</b>
	<b>09:57AM</b>		<b>Interval</b>
Free Triiodothyronine (FT3)	3.14	pg/mL	2.6 - 4.2
CLIA			

**Comment**

Parameter	Unit	Cord Blood	Upto 2 Month Adult	1st Trimester	2nd Trimester	3rd Trimester
FT3	Pg/mL	0.15 - 3.91	2.4 - 5.6	2.6 - 4.2	2.11 - 3.83	1.96 - 3.38

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**Immunoassay**
**Extensive Thyroid Profile**

**Thyroid Stimulating Hormone (TSH) - Ultrasensitive\*, Serum**

<b>Date</b>	<b>01/Jun/2024</b>	<b>Unit</b>	<b>Bio Ref Interval</b>
	<b>09:57AM</b>		
Thyroid Stimulating Hormone	<b>0.279</b>	μIU/mL	0.38 - 5.33
CLIA			

**Interpretation**

Parameter	Unit	Premature (28 - 36 Weeks)	Cord Blood (> 37 weeks)	Upto 2 Month	1st Trimester	2nd Trimester	3rd Trimester
TSH	uIU/ml	0.7 - 27.0	2.3 - 13.2	0.5 - 10	0.05 - 3.7	0.31 - 4.35	0.41 - 5.18

Increased in primary Hypothyroidism.  
Decreased in primary Hyperthyroidism

**Note :** TSH levels are subject to circadian variation, reaching peak levels between 2 – 4 am and at a minimum between 6 – 10 pm. The variation is of the order of 50% - 206 %, hence time of the day has influence on the measured serum TSH concentrations.

**Vitamin B12 (Vit- B12), (Cyanocobalamin)\*, Serum**

<b>Date</b>	<b>01/Jun/2024</b>	<b>Unit</b>	<b>Bio Ref Interval</b>
	<b>09:57AM</b>		
Vitamin B12	<b>255</b>	pg/mL	120 - 914
CLIA			

**Interpretation**
**Note:- Vitamin B12 (Cobalamin)**

Vitamin B12 is tested for patients with GIT disease, Neurological disease, psychiatric disturbances, malnutrition, alcohol abuse.

Increased in chronic renal failure, severe CHF.

Decreased in megaloblastic anemia.

**Advise:** CBC, peripheral smear, serum folate levels, intrinsic factor antibodies (IFA), bone marrow examination, if Vit B12 deficient.

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**Immunoassay**

SIN No:DN1266781

**Extensive Thyroid Profile**

Test Name	Result	Unit	Bio Ref Interval
<b>Free T4 ,Serum*</b>			
Free Thyroxine (FT4) CLIA	0.89	ng/dL	0.58 - 1.64

Kindly correlate with clinical findings

**\*\*\* End Of Report \*\*\*****Dr. Mini Singhal M.D.**  
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