





Patient NameCentreAge/GenderOP/IP No/UHIDMaxID/Lab IDCollection Date/TimeRef DoctorReporting Date/Time

Clinical Biochemistry

Result Unit Bio Ref Interval

CPK-MB*

Test Name

CPK-MB **36** U/L 0.00-26.92

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Clinical Biochemistry

C-Reactive Protein (CRP)*, Serum

Date 28/Dec/2022 Unit **Bio Ref Interval**

01:11PM

CRP 67.4 mg/L < 10

Turbitimetric

Interpretation This helps in detecting neonatal septicemia, meningitis and useful to assess the activity of inflammatory diseases like rheumatoid arthritis. It is increased after myocardial infarction, stress, trauma, infection, inflammation, surgery, or neoplastic proliferation. The increase with inflammation occurs within 6-12 hours and peaks at about 48 hours.

Calcium, Serum*

Date 28/Dec/2022 Unit **Bio Ref Interval**

01:11PM

Calcium (Total) 7.4 8.4-10.2 mg/dl

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.

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Clinical Biochemistry

Liver Function Test (LFT)*, Serum

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Total Protein Biuret	6.70	g/dL	6.3–8.2
Albumin BCG	2.7	g/dl	3.5-5.2
Globulin Calculated	4.0	g/dl	2.3 - 3.5
A.G. ratio Calculated	0.7		1.2 - 1.5
Bilirubin (Total) Diazo	1.9	mg/dl	0.2–1.3
Bilirubin (Direct) Diazo	0.7	mg/dl	0-0.3
Bilirubin (Indirect) Calculated	1.20	mg/dl	0.1 - 1.0
SGOT- Aspartate Transaminase (AST) IFCC without pyridoxal phosphate	3436	U/L	0-32
SGPT- Alanine Transaminase (ALT) IFCC without pyridoxal phosphate	1489	U/L	0-35
AST/ALT Ratio Calculated	2.31	Ratio	
Alkaline Phosphatase	227	U/L	38 - 126
GGTP (Gamma GT), Serum ENZYMATIC COLORIMETRIC ASSAY	38.0	U/L	12-43

Interpretation AST/ALT Ratio: -

In Case of deranged AST and/or ALT, the AST/ALT ratio is > 2.0 in alcoholic liver damage and < 2.0 in non – alcoholic liver damage

Kindly correlate with clinical findings

*** End Of Report ***

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Clinical Biochemistry



Shulehangi Dr Shubhangi Shalley MBBS, MD (Pathology)

Consultant pathologist

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Hematology SIN No: B2B2865589

Test Name Result Unit Bio Ref Interval

Peripheral Smear Examination*, EDTA

Peripheral Smear Examination

Light Microscopy

RBC picture shows mild anisocytosis with presence of microcytes, normocytes and few target cells. 5 NRBCs/100 WBCs noted.

Leucocytosis with neutrophilia noted.(absolute neutrophil count=41.9X10^3/ul). Toxic granules noted.

Platelets are in clumps and appear to be adequate manually.

IMPRESSION: Microcytic hypochromic anaemia with peripheral neutrophilia.

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Hematology

Prothrombin Time (PT-INR)*, Sodium Citrate

Date 28/Dec/2022 Unit Bio Ref Interval

01:11PM

Prothrombin Time (PT) 33.6 Sec 12.1 - 15.1

Photo-Optical-Nephlometry

MNPT Value 12.4 Sec

INR 2.70

Interpretation

(Syn: - Prothrombin Time)

PT is the test which checks the "extrinsic coagulation" pathway and is useful for detecting coagulation deficiency, liver disease and disseminated intravascular Coagulation (DIC).

PT can also be expressed as International normalized ratio (INR) used for monitoring warfarin therapy.

Raised PT value seen in - factor deficiency (Fibrinogen (I), Prothrombin (II), factor V, VII, X), oral anticoagulation therapy, liver diseases, Vitamin K deficiency and DIC.

Advice: - 'PT mixing study', 'specific factor(s) assay'may be added on for further evaluation.

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Hematology

CBC (Complete Blood Count)*, Whole Blood EDTA

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Haemoglobin Modified cyanmethemoglobin	7.3	g/dl	12.0 - 15.0
Packed Cell, Volume Calculated	23.3	%	40-50
Total Leucocyte Count (TLC Electrical Impedance) 48.29	10~9/L	4.0-10.0
Nucleated RBCs	2.73	/100WBCs	
RBC Count Electrical Impedance	3.33	10~12/L	3.8-4.8
MCV Electrical Impedance	70.0	fL	83-101
MCH Calculated	22.0	pg	27-32
MCHC Calculated	31.4	g/dl	31.5-34.5
Platelet Count Electrical Impedance	150	10~9/L	150-410
platelets seen in clumps			
MPV Calculated	7.0	fl	7.8-11.2
RDW Calculated	19.8	%	11.5-14.5
Differential Cell Count VCS / Light Microscopy			
Neutrophils	86.9	%	40-80
Lymphocytes	9.7	%	20-40
Monocytes	3.4	%	2-10
Eosinophils	0.0	%	1-6
Basophils	0.0	%	0-2
Absolute Leukocyte Coun Calculated from TLC & DLC	t		
Absolute Neutrophil Count	41.96	10~9/L	2.0-7.0
Absolute Lymphocyte Coun	t 4.7	10~9/L	1.0-3.0
Absolute Monocyte Count	1.64	10~9/L	0.2-1.0

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Hematology SN N- P079365590

Kindly correlate with clinical findings

*** End Of Report ***

Dr Shubhangi Shalley MBBS, MD (Pathology) Consultant pathologist

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employees. Liability of Max Healthcare for deficiency of services, or other errors and omissions shall be limited to fee paid by the patient for the relevant laboratory services.







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

> **Immunoassay**

Trop I, (High Sensitive)*

Date 28/Dec/2022 Unit **Bio Ref**

01:11PM Interval

Sample Type :. **EDTA**

Trop I 0.43 ng/ml < 0.02

Ref Range

"Important Note: The newly introduced high sensitive Trop I detects the analyte at a much lower concentration of 0.02 ng/mL. Thus the cut off reference range has been changed to 0.02 ng/mL"

Troponin I (High Sensitive) is a cardio-specific, highly sensitive marker for myocardial injury. Compared to contemporary troponin assays, high sensitive trop I demonstrate significantly improved precision at ≤ 0.02 ng/mL, allowing better discrimination of small differences in cardiac troponin values between serial measurements.

Clinical performance of high sensitive Trop I at cut of ≥ 0.02 ng/mL were as follows:

Hrs after admission to Emergency Department	Diagnostic sensitivity (% MI correctly diagnosed) %	Diagnostic Specificity (% non-MI Correctly Diagnosed) %	Positive Predictive Value (PPV- Probability of MI Diagnosis) %	Negative Predictive Value (NPV-Probability of non- MI diagnosis)
Base Line	86	90	61	97
$\geq 1-3 \text{ hr}$	95	90	55	99
$\geq 3-6 \text{ hr}$	93	90	55	99
$\geq 6 - 9 \text{ hr}$	99	86	52	1

Trop I is increased in congestive heart failure, acute and chronic trauma, electrical cardioversion, hypotension, hypotension, arrhythmias, pulmonary embolism, severe asthma, sepsis, critical illness, myocarditis, stroke, non-cardiac surgery, extreme exercise, drug toxicity (adriamycin, 5-fluorouracil, herceptin, snake venoms), end stage renal disease, and rhabdomyolysis with cardiac injury. These other etiologies rarely demonstrate the classic rising and falling pattern experienced with a MI which highlights the importance of serial monitoring when the clinical scenario is confusing.

Kindly correlate with clinical findings

*** End Of Report ***

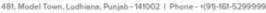
Dr Shubhangi Shalley MBBS, MD (Pathology) Consultant pathologist

Shulchange

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Clinical Biochemistry
RFT BIO 1

SIN No. B2B2865589

Urea, Serum*

Date 28/Dec/2022 Unit Bio Ref Interval 01:11PM

Urea 100.0 mg/dl 15 - 36
Urease GLDH

Creatinine, Serum*

Date 28/Dec/2022 Unit Bio Ref
01:11PM Interval

eGFR 29.39 ml/min/1.73 $_{\rm MDRD}$

Ref. Range

eGFR - Estimated Glomerular Filteration Rate is calculated by MDRD equation which is most accurate for GFRs \leq 60ml / m /1.73 m².MDRD equation is used for adult population only.

Category	Ref Interval (ml / min / 1.73 m²)	Condition
G1	≥90	Normal or High
G2	60 - 89	Mildly Decreased
G3a	45 - 59	Mildly to Moderately Decreased
G3b	30 - 44	Moderately to Severly Decreased
G4	15 - 29	Severly Decreased
G5	< 15	Kidney failure

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Clinical Biochemistry
RFT BIO 1

SIN No R2R2865589

Sodium, Serum*

Date 28/Dec/2022 Unit Bio Ref Interval

01:11PM

Sodium 129.0 mmol/l 135-148

Potassium, Serum*

ISE Indirect

Date 28/Dec/2022 Unit Bio Ref Interval

01:11PM

Potassium **5.5** mmol/l 3.5 - 5.3

Chloride, Serum*

ISE Indirect

Date 28/Dec/2022 Unit Bio Ref Interval

01:11PM

Chloride 97.0 mmol/l 101-111

ISE Indirect

Dr Shubhangi Shalley
MBBS, MD (Pathology)

Kindly correlate with clinical findings

*** End Of Report ***

Consultant pathologist

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SEROLOGY SPECIAL.

Dengue Fever Panel (Elisa)

Test Name Result Unit Bio Ref Interval

Elisa Dengue IgG Antibody, Serum*

Dengue IgG Negative (2.10 Units) Index

Ref. Range

Negative < 9.0 Equivocal 9.0 - 11.0 Positive >11

Comment:

- Primary dengue virus infection is characterized by elevations in specific IgM antibody in 3 to 5 days after the onset of symptoms.
- IgG levels also become elevated after 10 to 14 days after the onset of symptoms. During secondary infection, IgM levels generally rise more slowly and reach lower levels than in primary infection, while IgG levels rise rapidly from 1 to 2 days after the onset of symptoms.
- Serological cross-reactivity across the flavi virus group (dengue virus, St. Louis encephalitis, Japanese encephalitis, West Nile virus and yellow fever virus) is common.

Note: Recommended test is NS1 Antigen by ELISA in the first 5 days of fever. After 7-10 days of fever, the recommended test is Dengue fever antibodies IgG & IgM by ELISA

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SEROLOGY SPECIAL.

Dengue Fever Panel (Elisa)

Test Name Result Unit Bio Ref Interval

Elisa Dengue IgM Antibody, Serum*

Dengue IgM Negative (1.50 Units) Index

Ref. Range

Negative < 9.0 Equivocal 9.0 - 11.0 Positive >11

Comment:

- Primary dengue virus infection is characterized by elevations in specific IgM antibody in 3 to 5 days after the onset of symptoms.
- IgG levels also become elevated after 10 to 14 days after the onset of symptoms. During secondary infection, IgM levels generally rise more slowly and reach lower levels than in primary infection, while IgG levels rise rapidly from 1 to 2 days after the onset of symptoms.
- Serological cross-reactivity across the flavi virus group (dengue virus, St. Louis encephalitis, Japanese encephalitis, West Nile virus and yellow fever virus) is common.
- A negative results does not preclude the possibility of early dengue virus infection.

Note: Recommended test is NS1 Antigen by ELISA in the first 5 days of fever. After 7-10 days of fever, the recommended test is Dengue fever antibodies IgG & IgM by ELISA

Dengue NS 1 Antigen Test (Elisa)*

Dengue NS 1 Antigen Negative (0.01 Ratio) Ratio

Ref. Range

 $\begin{array}{ll} \mbox{Negative} & \mbox{Ratio} < 0.50 \\ \mbox{Equivocal} & 0.50 \le \mbox{Ratio} \ \mbox{-} < 1.00 \\ \mbox{Positive} & \mbox{Ratio} \ge 1.00 \end{array}$

Comment:

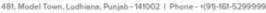
- The detection of NS1 antigen has been described as an alternative method for early diagnosis of dengue virus infection.
- NS1 antigen was found circulating from the first day and up to 9 days after the onset of fever, with comparable levels observed in primary and secondary infections.
- A negative results does not preclude the possibility of early dengue virus infection.

Note: Recommended test is NS1 Antigen by ELISA in the first 5 days of fever. After 7-10 days of fever, the recommended test is Dengue fever antibodies IgG & IgM by ELISA

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SEROLOGY SPECIAL.

Dengue Fever Panel (Elisa)

Bio Ref Interval Result Unit

Kindly correlate with clinical findings

Test Name

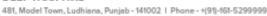
MBBS, MD (Microbiology) Senior Consultant

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Serology Special

GDY N. DODOGGGGG

Rapid Dengue Panel

Result Unit Bio Ref Interval

Rapid Card Test-Dengue NS1 Antigen*, Serum

Immunochromatography

Test Name

MBBS, MD (Microbiology) Senior Consultant

NS1 Antigen Card

Non reactive

Advise: Confirmatory tests 'NS1 Antigen ELISA and Dengue PCR

Kindly correlate with clinical findings

*** End Of Report ***

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Serology

Rapid Dengue Panel

Test Name Result Unit Bio Ref Interval

Dengue Serology (Ig M & Ig G), Serum/EDTA*

Immunochromatography

Antibody IgM Non reactive

Immunochromatography

Antibody IgG Non reactive

Immunochromatography

Interpretation

This test detects the presence of antibodies to dengue virus in the specimen and should not be used as the sole criterion for the diagnosis of dengue virus infection. In early infections and some secondary infections, detectable levels of IgM antibodies may be low.

Some patients may not produce detectable levels of antibody within the first seven to ten days after infection. If the test result is negative and clinical symptoms persist, patients should be retested 3-4 days after the first specimen.

Serological cross-reactivity across the flavi virus group (dengue virus, St. Louis encephalitis, Japanese encephalitis, West Nile virus and yellow fever virus) is common. A negative results does not preclude the possibility of early dengue virus infection.

The report is based on screening test and is provisional.

Advise: "Dengue IgM capture ELISA or Dengue PCR" for diagnosis of acute infection

Kindly correlate with clinical findings

*** End Of Report ***

Dr. Muktanjali Arya MBBS, MD (Microbiology) Senior Consultant Results to follow:

Blood Gas Analysis with Electrolytes: 28/Dec/2022 02:05 PM

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