ISO 9001:2008 International Standard Certifications
LIC No. QACR91/3585
NABL M-0520
Unipath SPECIALTY LABORATORY Ltd.
Regd. Office : 102, 1st Floor, Sanoma Plaza, Opp. Parimal Garden, Beside JMC House, Ellisbridge, Ahmedabad-380 006.
Ph. : 91-79-49006803 / 13 I Mobile : 7600029630

TEST REPORT

Reg. No.	: 50502500720	**Reg. Date** : 09-May-2025 07:15	**Ref.No** :	**Approved On**	: 09-May-2025 09:24
Name	: Mr. P . R DHOLAKIA			**Collected On**	: 09-May-2025 07:16
Age	: 77 Years	**Gender:** Male	**Pass. No. :**	**Dispatch At**	:
Ref. By	: Dr. PARIMAL SALVI M.S.			**Tele No.**	: 9898258040
Location	:				

Test Name		Results	Units	Bio. Ref. Interval
		Complete Blood Count **Specimen: EDTA blood**		
Hemoglobin				
Hemoglobin(SLS method)	L	**8.9**	g/dL	13.0 - 17.0
Hematocrit (calculated)	L	**27.9**	%	40 - 50
RBC Count(Ele.Impedence)	L	**3.09**	X 10^12/L	4.5 - 5.5
MCV (Calculated)		90.5	fL	83 - 101
MCH (Calculated)		28.9	pg	27 - 32
MCHC (Calculated)		31.9	g/dL	31.5 - 34.5
RDW (Calculated)	H	**17.4**	%	11.5 - 14.5
Differential WBC count (Impedance and flow)				
Total WBC count		5500	/µL	4000 - 10000
Neutrophils	H	**72**	%	38 - 70
Lymphocytes		21	%	21 - 49
Monocytes		05	%	3 - 11
Eosinophils		02	%	0 - 7
Basophils		00	%	0 - 1
Platelet				
Platelet Count (Manual)		282000	/cmm	150000 - 410000
MPV		7.90	fL	6.5 - 12.0
Platelets appear on the smear		Adequate		

EDTA Whole Blood

Note: All abnormal hemograms are reviewed and confirmed microscopically.Peripheral blood smear and malarial parasite examination are not part of CBC report.

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Test done from collected sample.

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Reg. No.	: 50502500720	**Reg. Date** : 09-May-2025 07:15	**Ref.No** :	**Approved On**	: 09-May-2025 12:11
Name	: Mr. P . R DHOLAKIA			**Collected On**	: 09-May-2025 12:08
Age	: 77 Years	**Gender:** Male	**Pass. No. :**	**Dispatch At**	:
Ref. By	: Dr. PARIMAL SALVI M.S.			**Tele No.**	: 9898258040
Location	:				

Test Name		Results	Units	Bio. Ref. Interval
FASTING PLASMA GLUCOSE				
Specimen: Fluoride plasma				
Fasting Plasma Glucose *Hexokinase*	H	**110.74**	mg/dL	Normal: <=99.0 Prediabetes: 100-125 Diabetes :>=126
Urine Glucose -F *Strip Test (God Pod)*		Not voided		Nil
Urine Acetone -F		Not voided		Negative

Flouride Plasma

Criteria for the diagnosis of diabetes:

1. HbA1c >/= 6.5 *

Or

2. Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.

Or

3. Two hour plasma glucose >/= 200mg/dL during an oral glucose tolerence test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water.

Or

4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >/= 200 mg/dL. *In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.

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Unipath
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Lab : 1st Floor, Akanksha Hospital, Nr. Shrushti English Medium School, Opp. Guruvilash Bunglow, Lambvel, Anand-388001 I Phone : 02692 - 307477 I Mobile : 7621000927
CIN : U85195GJ2009PLC057059

TEST REPORT

Reg. No.	: 50502500720	**Reg. Date :** 09-May-2025 07:15	**Ref.No :**	**Approved On**	: 09-May-2025 11:57
Name	: Mr. P . R DHOLAKIA			**Collected On**	: 09-May-2025 07:16
Age	: 77 Years	**Gender:** Male	**Pass. No. :**	**Dispatch At**	:
Ref. By	: Dr. PARIMAL SALVI M.S.			**Tele No.**	: 9898258040
Location	:				

Test Name	Results	Units	Bio. Ref. Interval
Creatinine	0.90	mg/dL	0.70 - 1.20
Alkaline picrate IFCC			

Creatinine is the most common test to assess kidney function. Creatinine levels are converted to reflect kidney function by factoring in age and gender to produce the eGFR (estimated Glomerular Filtration Rate). As the kidney function diminishes, the creatinine level increases; the eGFR will decrease. Creatinine is formed from the metabolism of creatine and phosphocreatine, both of which are principally found in muscle. Thus the amount of creatinine produced is, in large part, dependent upon the individual's muscle mass and tends not to fluctuate much from day-to-day. Creatinine is not protein bound and is freely filtered by glomeruli. All of the filtered creatinine is excreted in the urine.

Urea	40.0		15 - 40

Useful screening test for evaluation of kidney function. Urea is the final degradation product of protein and amino acid metabolism. In protein catabolism, the proteins are broken down to amino acids and deaminated. The ammonia formed in this process is synthesized to urea in the liver. This is the most important catabolic pathway for eliminating excess nitrogen in the human body. Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis), and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors). The determination of serum BUN currently is the most widely used screening test for the evaluation of kidney function. The test is frequently requested along with the serum creatinine test since simultaneous determination of these 2 compounds appears to aid in the differential diagnosis of prerenal, renal and postrenal hyperuremia.

Uric Acid (UA)	4.20	mg/dL	1.3 - 6.0
Method:Colorimetric IFCC, without P5P			

Serum

Uses

To monitor treatment of gout

To monitor hemotherapeutic treatement of neoplarms to avoid renal urate depositon.

Increase in - Renal failure , Gout , increased destrution of nucleoprotein like in leukemia ,hemolytic anemia, psoriasis, etc ,high protein diet,alochol consumption, etc.

Decrease in - Intake of uricosuric drugs like allopurinol, severe hepatocellular disease , defective renal tubular damage.

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TEST REPORT

Reg. No.	: 50502500720	**Reg. Date :** 09-May-2025 07:15	**Ref.No :**	**Approved On**	: 09-May-2025 11:58
Name	: Mr. P . R DHOLAKIA			**Collected On**	: 09-May-2025 07:16
Age	: 77 Years	**Gender:** Male	**Pass. No. :**	**Dispatch At**	:
Ref. By	: Dr. PARIMAL SALVI M.S.			**Tele No.**	: 9898258040
Location	:				

Test Name		Results	Units	Bio. Ref. Interval
		ELECTROLYTES		
Sodium (Na+) *Method:ISE*		136	mmol/L	136 - 145
Potassium (K+) *Method:ISE*		4.6	mmol/L	3.5 - 5.1
Chloride(Cl^-) *Method:ISE*	L	**96**	mmol/L	98 - 107
Serum				

NOTE:
The electrolyte panel is ordered to identify electrolyte, fluid, or pH imbalance. Electrolyte concentrations are evaluated to assist in investigating conditions that cause electrolyte imbalances such as dehydration, kidney disease, lung diseases, or heart conditions. Repeat testing of the electrolyte or its components may be used to monitor the patient's response to treatment of any condition that may be causing the electrolyte, fluid or pH imbalance.

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Age	: 77 Years	**Gender:** Male	**Pass. No. :**	**Dispatch At**	:
Ref. By	: Dr. PARIMAL SALVI M.S.			**Tele No.**	: 9898258040
Location	:				

Test Name		Results	Units	Bio. Ref. Interval
SGPT		46.80	U/L	0 - 49
UV without P5P				

Alanine aminotransferase (ALT) is present primarily in liver cells. In viral hepatitis and other forms of liver disease associated with hepatic necrosis, serum ALT is elevated even before the clinical signs and symptoms of the disease appear. Although serum levels of both aspartate aminotransferase (AST) and ALT become elevated whenever disease processes affect liver cell integrity, ALT is a more liver-specific enzyme. Serum elevations of ALT are rarely observed in conditions other than parenchymal liver disease. Moreover, the elevation of ALT activity persists longer than does AST activity.

Alkaline Phosphatase (ALP)	H	**240.60**	U/L	40 - 130
P-Nitrophenyl Phosphate, Amp Buffer				

Alkaline phosphatase (ALP) is present in a number of tissues including liver, bone, intestine, and placenta. The activity of ALP found in serum is a composite of isoenzymes from those sites and, in some circumstances, placental or Regan isoenzymes. Serum ALP is of interest in the diagnosis of 2 main groups of conditions-hepatobiliary disease and bone disease associated with increased osteoblastic activity. A rise in ALP activity occurs with all forms of cholestasis, particularly with obstructive jaundice. The response of the liver to any form of biliary tree obstruction is to synthesize more ALP. The main site of new enzyme synthesis is the hepatocytes adjacent to the biliary canaliculi. ALP is also elevated in disorders of the skeletal system that involve osteoblast hyperactivity and bone remodeling, such as Paget disease, rickets, osteomalacia, fractures, and malignant tumors. Moderate elevation of ALP may be seen in other disorders such as Hodgkin disease, congestive heart failure, ulcerative colitis, regional enteritis, and intra-abdominal bacterial infections.

SGOT	H	**53.00**	U/L	0 - 49
UV without P5P				

Serum
Aspartate aminotransferase (AST) is found in high concentrations in liver, heart, skeletal muscle, and kidney. AST is present in both cytoplasm and mitochondria of cells. In cases involving mild tissue injury, the predominant form of AST is that from the cytoplasm. Severe tissue damage results in more of the mitochondrial enzyme being released. High levels of AST can be found in cases such as myocardial infarction, acute liver cell damage, viral hepatitis, and carbon tetrachloride poisoning. Slight to moderate elevation of AST is seen in muscular dystrophy, dermatomyositis, acute pancreatitis, and crushed muscle injuries.Elevated aspartate aminotransferase (AST) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes.

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Ref. By	: Dr. PARIMAL SALVI M.S.			**Tele No.**	: 9898258040
Location	:				

Test Name	Results	Units	Bio. Ref. Interval
SERUM BILIRUBIN ESTIMATION			
Specimen: Serum			
TOTAL BILIRUBIN *Diazonium Ion,Blanked(Roche)*	0.40	mg/dL	0 - 1.1
DIRECT BILIRUBIN *Jendrassik Grof*	0.20	mg/mL	0 - 0.4
INDIRECT BILIRUBIN *Calculated*	0.20	mg/dL	0.0 - 1.00

Bilirubin is one of the most commonly used tests to assess liver function. Approximately 85% of the total bilirubin produced is derived from the heme moiety of hemoglobin, while the remaining 15% is produced from RBC precursors destroyed in the bone marrow and from the catabolism of other heme-containing proteins. After production in peripheral tissues, bilirubin is rapidly taken up by hepatocytes where it is conjugated with glucuronic acid to produce bilirubin mono- and diglucuronide, which are then excreted in the bile. The most commonly occurring form of unconjugated hyperbilirubinemia is that seen in newborns and referred to as physiological jaundice. The increased production of bilirubin, that accompanies the premature breakdown of erythrocytes and ineffective erythropoiesis, results in hyperbilirubinemia in the absence of any liver abnormality. In hepatobiliary diseases of various causes, bilirubin uptake, storage, and excretion are impaired to varying degrees. Thus, both conjugated and unconjugated bilirubin are retained and a wide range of abnormal serum concentrations of each form of bilirubin may be observed. Both conjugated and unconjugated bilirubins are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater.

Reference range For New born:

Cord(Premature) : <2.0 mg/dL

Cord(full term)) : <2.0 mg/dL

0-1 days (Premature) : 1-8 mg/dL

0-1 days (Full term) : 2-6 mg/dL

1-2 days (Premature) : 6-12 mg/dL

1-2 days (Full term) : 6-10 mg/dL

3-5 days (Premature) : 10.0-14.0 mg/dL

3-5 days (Full term) : 4.0-8.0 mg/dL

Useful for:

- Assessing liver function
- Evaluating wide range of diseases affecting the production, uptake, storage, metabolism, excretion of bilirubin.
- Monitoring the efficacy of neonatal phototherapy.

Protein with A/G ratio			
Specimen - Serum			
TOTAL PROTEIN *Method:Biuret*	7.20	g/dL	6.3 - 8.3
ALBUMIN *Bromcresol Green(BCG)*	3.74	g/dL	3.3 - 5.0

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Location	:				

Protein with A/G ratio
Specimen - Serum

GLOBULIN *Calculated*		3.46	g/dL	2.4 - 3.5
ALB/GLB Ratio *Calculated*	L	**1.08**		1.2 - 2.2

Serum

CLINICAL SIGNIFICANCE:

• Changes in the relative percentage of plasma proteins can be due to a change in the percentage of one plasma protein fraction. Often in such cases the amount of total protein does not Change.

• The A/G ratio is commonly used as an index of the distribution of Albumin and globulin fractions.

• Marked changes in this ratio can be Observed in cirrhosis of the liver, glomerulonephritis, nephrotic syndrome, Acute hepatitis, lupus erythematosus as well as in certain acute and chronic Inflammations.

• Total protein measurements are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney, or bone Marrow, as well as other metabolic or nutritional disorders

HYPOPROTEINEMIA:

• Loss Of Blood,
• Sprue,
• Nephrotic Syndrome,
• Severe Burns,
• Salt Retention Syndrome
• Kwashiorkor (Acute Protein Deficiency).

HYPERPROTEINEMIA:

• Severe Dehydration
• Multiple Myeloma.

---------- End Of Report ----------

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