Lifenity Genomic Laboratory DMCC
HDS Business Centre, Level 6, 601-608
JLT, Cluster M, P.O Box 502180, Dubai, UAE
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Patient Name	: MR.NASER NASER	**Registered On**	: 03-01-2024 20:21
Patient Id	: 6341	**Sample Collected On**	: 03-01-2024 21:54
Age/DOB/Gender	: 33Y/1991-01-01/Male	**Reported On**	: 04-01-2024 09:14
Nationality	: -	**Sample UID No.**	: D002W000001317
Customer Type	: -	**Customer Name**	: Self
Ref. Doctor Name	: Dr.SAJID	**Patient UID No.**	: -- (Other)
		Print Version	: v.1

RANDOM BLOOD SUGAR

Investigation	Result	Units	Biological Reference Interval
RANDOM BLOOD SUGAR	**205**	mg/dL	70-200
Sample Type :Plasma			
Method : GOD-POD			

Interpretation -

A blood sugar level of 200 milligrams per deciliter (mg/dL) or higher suggests diabetes.

--End Of Report--

Rajesh Thapa
Quality Manager
Technologist- Medical Laboratory
DHA No. 45935548-002

DR. Nirupama Sabhapathy
Chief Pathologist
Specialist Clinical Pathologist
DHA NO. 65077850-001

Lifenity Genomic Laboratory DMCC
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VITAMIN D3

Investigation	Result	Units	Biological Reference Interval
VITAMIN D3	**24.6**	ng/mL	Deficiency: <10 Insufficiency: 10 - 29 Sufficiency: 30 - 100 Toxicity: > 100

Sample Type :Serum

Method : CLIA

Interpretation -

Studies show that 25-hydroxyvitamin D2 and D3 (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 less than 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.

Comments:

Baseline biochemical work-up of suspected cases of rickets and osteomalacia should include measurement of serum calcium, phosphorus, PTH, and 25-OH-VitD. In patients where testing is not completely consistent with the suspected diagnosis, in particular, if serum 25-OH-VitD levels are greater than 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.

--End Of Report--

Rajesh Thapa
Quality Manager
Technologist- Medical Laboratory
DHA No. 45935548-002

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IRON, SERUM

Investigation	Result	Units	Biological Reference Interval
IRON SERUM	110	µg/dL	65-175
Sample Type :Serum			
Method : Pyridyl azo dye			

Comments:

Increased : Pernicious, aplastic, and hemolytic anemias; hemochromatosis, acute leukemia, lead poisoning, acute hepatitis, vitamin B6 deficiency, thalassemia, excessive Fe therapy, repeated transfusions, acute Fe poisoning (children), and nephritis
Decreased: Iron-deficiency anemia, remission of PA; acute and chronic infection, carcinoma, nephrosis, hypothyroidism, postoperative state, and kwashiorkor

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Rajesh Thapa
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DR. Nirupama Sabhapathy
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THYROID FUNCTION TEST (TOTAL)

Investigation	Result	Units	Biological Reference Interval
TOTAL T3 Sample Type :Serum Method : CLIA	1.2	ng/mL	0.8-2.15
TOTAL T4 Sample Type :Serum Method : CLIA	73.4	ng/mL	52-127
TSH Sample Type :Serum Method : CLIA	0.5	µIU/ml	0.3-4.5

Interpretation -

Serum T3 (triiodothyronine) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed TSH and normal free T4 concentrations.

Detectable concentrations of antithyroperoxidase (anti-TPO) antibodies are observed in patients with autoimmune thyroiditis and may cause the destruction of thyroid tissue, eventually resulting in hypothyroidism. Anti-TPO antibodies are measured in all specimens with elevated TSH concentrations.

--End Of Report--

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Quality Manager
Technologist- Medical Laboratory
DHA No. 45935548-002

DR. Nirupama Sabhapathy
Chief Pathologist
Specialist Clinical Pathologist
DHA NO. 65077850-001

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LIPID PROFILE

Investigation	Result	Units	Biological Reference Interval
TOTAL CHOLESTEROL Sample Type :Serum Method : Vitros Microslide	**267**	mg/dL	<200 Desirable 200-239 Borderline high >240 High
TRIGLYCERIDE SERUM Sample Type :Serum Method : AST- Vitros	**301**	mg/dL	Normal: <150 Borderline high: 150-199 High: 200-499 Very high: >500
HDL CHOLESTEROL Sample Type :Serum Method : Direct measure, PTA/MgCl2-VITROS	**37**	mg/dL	High risk: < 40 Low risk: > 60
LDL CHOLESTEROL Sample Type :Serum Method : Calculated	**169.80**	mg/dL	Optimal: <100 Near optimal: 100-129 Borderline high: 130-159 High: 160-189 Very high: >190
VLDL CHOLESTEROL Sample Type :Serum Method : Calculated	**60.20**	mg/dL	< 30
NON HDL CHOLESTEROL Sample Type :Serum Method : Calculated	**230.00**	mg/dL	Desirable < 130 Borderline 130 - 159 High >160

Rajesh Thapa
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TG/HDL Ratio	**8.14**	--	Ideal: </=2.0 Good: </=6.0 Bad: >6.0

Sample Type :Serum

TOTAL CHOLESTEROL HDL RATIO	**7.22**	--	Low risk 3.3 - 4.4 Average Risk 4.5 - 7.0 Moderate Risk 7.1 - 11.0 High Risk >11.0

Sample Type :Serum
Method : Calculated

LDL HDL ratio	**4.59**	--	Low Risk < 3.0 Borderline 3.1 - 6.0 High Risk >6.0

Sample Type :Serum
Method : Calculated

Interpretation -

A complete cholesterol test includes the calculation of four types of fats in your blood:
Total cholesterol. This is a sum of your blood's cholesterol content.
Low-density lipoprotein (LDL) cholesterol. This is called the "bad" cholesterol. Too much of it in your blood causes the buildup of fatty deposits (plaques) in your arteries (atherosclerosis), which reduces blood flow. These plaques sometimes rupture and can lead to a heart attack or stroke.
High-density lipoprotein (HDL) cholesterol. This is called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and your blood flowing more freely.
Triglycerides. Triglycerides are a type of fat in the blood. When you eat, your body converts calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels.

--End Of Report--

Rajesh Thapa
Quality Manager
Technologist- Medical Laboratory
DHA No. 45935548-002

DR. Nirupama Sabhapathy
Chief Pathologist
Specialist Clinical Pathologist
DHA NO. 65077850-001

LIFENITY

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RENAL FUNCTION TEST

Investigation	Result	Units	Biological Reference Interval
BLOOD UREA Sample Type :Serum Method : Urease, colorimetric	24	mg/dL	12.84-42.8
BLOOD UREA NITROGEN Sample Type :Serum Method : Urease, colorimetric	11.21	mg/dL	6-20
CREATININE SERUM Sample Type :Serum Method : Enzymatic-VITROS, IFCC-IDMS Standardized	0.8	mg/dL	0.7-1.35
URIC ACID SERUM Sample Type :Serum Method : URICASE, ENZYMATIC COLORIMETRIC	3.7	mg/dL	3.5-8.5
e-GFR Sample Type :Serum	111	mL/min/1.73m2	75-190
BUN CREATININE RATIO Sample Type :Serum Method : Calculated	14.01	--	10-20

Interpretation -

Interpretation of renal function tests requires considering multiple factors, including the patient's age, sex, muscle mass, medications, and clinical history. It's important to note that renal function tests are not diagnostic on their own and are often used in conjunction with other clinical assessments and imaging studies to evaluate kidney function comprehensively.

Abnormal results may indicate various kidney conditions, including acute or chronic kidney disease, glomerulonephritis, kidney infections, kidney stones, and renal tubular disorders. They can also point to non-renal conditions such as heart failure, liver disease, or dehydration.

Rajesh Thapa
Quality Manager
Technologist- Medical Laboratory
DHA No. 45935548-002

DR. Nirupama Sabhapathy
Chief Pathologist
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DHA NO. 65077850-001

Lifenity Genomic Laboratory DMCC
HDS Business Centre, Level 6, 601-608
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Rajesh Thapa
Quality Manager
Technologist- Medical Laboratory
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DR. Nirupama Sabhapathy
Chief Pathologist
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LIFENITY

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LIVER FUNCTION TEST

Investigation	Result	Units	Biological Reference Interval
ALT (SGPT) Sample Type :Serum Method : ALTv- VITROS	40	U/L	7-55
AST (SGOT) Sample Type :Serum Method : AST- Vitros	26	U/L	Males 0-11 months: not established 1-13 years: 8-60 >/=14 years: 8-48 Females 0-11 months: not established 1-13 years: 8-50 >/=14 years: 8-43
ALKALINE PHOSPHATASE Sample Type :Serum Method : NPP, AMP Buffer-VITROS	66	U/L	30-120
GAMMA GT SERUM Sample Type :Serum Method : Vitros Microslide	**73**	U/L	5-61
BILIRUBIN TOTAL SERUM Sample Type :Serum Method : Diphylline, Diazonium Salt-VITROS	0.6	mg/dL	0.1-1.3
BILIRUBIN DIRECT Sample Type :Serum Method : Spectrophotometer	0.2	mg/dL	< 0.3
BILIRUBIN INDIRECT Sample Type :Serum	0.4	mg/dL	0-6 days: 0.1 – 1.0 7-14 days: < 15.0 15 days to 17 years: < 1.0 >/=18 years: > 1.2 mg/ dL

Rajesh Thapa
Quality Manager
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Method : Direct measured

TOTAL PROTEIN SERUM	6.9	g/dL	6.3-8.2
Sample Type :Serum			
Method : Biuret			
ALBUMIN SERUM	4.3	g/dL	3.5-5.0
Sample Type :Serum			
Method : Dye Binding BCG			
GLOBULIN	2.60	g/dL	2.3-3.5
Sample Type :Serum			
Method : Calculated			
ALBUMIN GLOBULIN RATIO	1.65	--	1.2-1.8
Sample Type :Serum			
Method : Calculated			

Interpretation -

Hepatic function panel results are not diagnostic of a specific condition; they indicate that there may be a problem with the liver. In a person who does not have symptoms or identifiable risk factors, abnormal liver test results may indicate a temporary liver injury or reflect something that is happening elsewhere in the body-such as in the skeletal muscles, pancreas, or heart. It may also indicate early liver disease and the need for further testing and periodic monitoring.

Results of liver panels are usually evaluated together. Several sets of results from tests performed over a few days or weeks are often assessed together to determine if a pattern is present. Each person will have a unique set of test results that will typically change over time. A healthcare practitioner evaluates the combination of liver test results to gain clues about the underlying condition. Often, further testing is necessary to determine what is causing the liver damage or disease.

--End Of Report--

Rajesh Thapa
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Technologist- Medical Laboratory
DHA No. 45935548-002

DR. Nirupama Sabhapathy
Chief Pathologist
Specialist Clinical Pathologist
DHA NO. 65077850-001

LIFENITY

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Nationality	: -	**Sample UID No.**	: D002W000001314
Customer Type	: -	**Customer Name**	: Self
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COMPLETE BLOOD COUNT (CBC)

Investigation	Result	Units	Biological Reference Interval
HAEMOGLOBIN	16.1	g/dL	13.5-17.5
HEMATOCRIT	48.6	%	37-53
RBC COUNT	5.38	X 10^6/µL	4.50-5.90
MCV	90.4	fL	77-100
MCH	29.9	Pg	26-34
MCHC	33.1	g/dL	32-36
RDW-CV	13.4	%	11.5-16
PLATELET COUNT	307	x10^3/ul	150-450
MPV	9.9	fL	7.5-12.0
TOTAL LEUKOCYTE COUNT	5.72	x10^3/ul	4.5-11.0
NEUTROPHIL	51.4	%	40-73
LYMPHOCYTE	38.8	%	25-45
MONOCYTE	6.9	%	4-12
EOSINOPHIL	1.8	%	0-7
BASOPHIL	1.1	%	0-2
ABSOLUTE NEUTROPHIL COUNT	2.91	x10^3/ul	1.5-7.0
ABSOLUTE LYMPHOCYTE COUNT	2.21	x10^3/ul	1.1-5.0
ABSOLUTE EOSINOPHIL COUNT	**0.1**	x10^3/ul	0.15-0.5
ABSOLUTE MONOCYTE COUNT	0.4	x10^3/ul	0.2-0.8
ABSOLUTE BASOPHIL COUNT	0.07	x10^3/ul	0-0.15

Sample Type :EDTA Whole Blood

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Interpretation -

Method: EDTA Whole Blood: Tests done on Automated Five Part Cell Counter. (Hb by Photometry method .RBC & PLT by Electric Impedance, PCV by Numeric Integration method. WBC and Differential count by Double Hydrodynamic Sequential System (DHSS). Other parameters Calculated.) All Abnormal Haemograms are reviewed confirmed microscopically.

Disclaimer:

1) The above result relate only to the specimens. Received and tested in laboratory and should be always correlate with clinical findings and other laboratory markers.

2) Improper specimen collection, handling. Storage and transportation may result in false negative/Positive results.

Comments:

A complete blood count (CBC) test is a commonly performed blood test that provides important information about the components of your blood. It measures various parameters related to red blood cells, white blood cells, and platelets. **Useful for :**Detecting and diagnosing medical conditions, Preoperative assessment, Detecting and diagnosis disorders of RBCs, WBCs & Platelets.As a Screening tool to confirm a hematologic disorder, to establish or rule out a diagnosis, to detect an unsuspected hematologic disorder, or to monitor effects of radiation or chemotherapy.

Reference: Horiba Yumizen 550, Performance and Reference: Tools for Accreditation 3.4.15. Reference Values, page 47

--End Of Report--

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HAEMOGLOBIN AIC

Investigation	Result	Units	Biological Reference Interval
HAEMOGLOBIN AIC	**10.6**	%	Non-Diabetic: < 5.7 Pre-Diabetic: 5.7 - 6.4 Diabetic:- Good Control: 6.0 - 7.0 Fair control: 7.1 - 8.0 Poor Control: > 8.0

Sample Type :EDTA Whole Blood

Method : HPLC

Test Comment : Value checked, suggested clinical correlation.

Interpretation -

Achieving A1C targets of <7% (has been shown to reduce microvascular complications of type 1 and type 2 diabetes when instituted early in the course of disease, the greatest number of complications will be averted by taking patients from very poor control to fair/good control.

--End Of Report--

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Rajesh Thapa
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