



Ms. JOY KENDI

PID NO :

Age : 29 Years Sex : Female

DOB: 05-Oct-1995



Reference : Dr. AMAIZAH ISHTIAQ

Sample Collected At :

CITICARE MEDICAL CENTER

Unit G03, Al Barsha South Bldg, Al Barsha South
Third, Dubai

VID : 5060103523

Registered on :

13-Jun-2025 03:30 PM

Collected on :

12-Jun-2025 06:30 PM

Reported on :

13-Jun-2025 04:37 PM

Investigation	Observed Value	Flag	Unit	Biological Reference Interval	Method
COMPLETE BLOOD COUNT (CBC)					
HEMOGLOBIN	11.9	L	g/dL	12 - 15.5	Photometric
RBC COUNT	4.1		10 ⁶ /μL	3.9 - 5	Electrical Impedance
HEMATOCRIT	36.2		%	35 - 45	Calculation
MCV	88.7		fL	82 - 98	Calculation
MCH	29.2		pg	27 - 32	Calculation
MCHC	33.0		g/dL	32 - 37	Calculation
* RDW	13.6		%	11.9 - 15.5	Calculation
* RDW-SD	42.00		fL		Calculation
MPV	8.8		fL	7.6 - 10.8	Calculation
PLATELET COUNT	265		10 ³ /uL	150 - 450	Electrical Impedance
* NUCLEATED RBC (NRBC)	0.1		/100 WBC		VCS 360 Technology
* ABSOLUTE NRBC COUNT	0.01		10 ³ /uL		Calculation
TOTAL & DIFFERENTIAL COUNT (DC)					
WBC COUNT	4.5		10 ³ /μL	4 - 11	Electrical Impedance
NEUTROPHILS	53		%	40 - 75	VCS 360 Technology
LYMPHOCYTES	37		%	30 - 60	VCS 360 Technology
EOSINOPHILS	5		%	0 - 6	VCS 360 Technology
MONOCYTES	5		%	1 - 6	VCS 360 Technology
BASOPHILS	0		%	0 - 1	VCS 360 Technology
ABSOLUTE COUNT					
ABSOLUTE NEUTROPHIL COUNT	2.4		10 ³ /uL	1.6 - 8.25	Calculation
ABSOLUTE LYMPHOCYTE COUNT	1.7		10 ³ /uL	1.2 - 6.6	Calculation
ABSOLUTE MONOCYTE COUNT	0.2		10 ³ /uL	0.04 - 0.66	Calculation
ABSOLUTE EOSINOPHIL COUNT	0.2		10 ³ /uL	0 - 0.66	Calculation
ABSOLUTE BASOPHIL COUNT	0		10 ³ /uL	0 - 0.11	Calculation

Sample Type: EDTA Whole Blood

DR. ADLEY MARK FERNANDES
M.D (Pathology)
Pathologist

Vyoma V. Shah

DR. VYOMA SHAH
M.D (Pathology)
Clinical Pathologist



M RASHID CHENANGADATH
Laboratory Technologist

Printed on: 13-Jun-2025 05:41 PM

Test result pertains only to the sample tested and to be interpreted in the light of clinical history. These tests are accredited under ISO 15189 unless specified by (*).





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Investigation	Observed Value	Flag	Unit	Biological Reference Interval
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CALCIUM

(Serum, NM-BAPTA)

10.4

H

mg/dL

8.6 - 10.0

INTERPRETATION :

- Increased level is seen in Hyperparathyroidism, Infections that cause granulomas such as tuberculosis and certain fungal and mycobacterial infections, Multiple myeloma, T cell lymphoma and certain other cancers, Metastatic bone tumor, Paget disease, Use of certain medicines such as lithium, tamoxifen, and thiazides.
- Decreased level is seen in Kidney failure, Low blood level of albumin, Liver disease, Magnesium deficiency, Pancreatitis, Vitamin D deficiency

CHLORIDE (CL)

(Serum, ISE (Indirect))

105

mmol/L

98 - 107

INTERPRETATION :

- Increased level is seen in dehydration, with ammonium chloride administration, with renal tubular acidosis (hyperchloremic metabolic acidosis) and with excessive infusion of normal saline, hyperparathyroidism.
- Decreased level with overhydration, congestive failure, syndrome of inappropriate secretion of ADH, vomiting, gastric suction, chronic respiratory acidosis, Addison disease, salt-losing nephritis, burns, metabolic alkalosis, and in some instances of diuretic therapy.

POTASSIUM (K)

(Serum, ISE (Indirect))

4.9

mmol/L

3.5 - 5.1

INTERPRETATION:

- Potassium (K) Low levels are noted in reduced intake of dietary potassium or excessive loss of potassium from the body due to diarrhea, prolonged vomiting or increased renal excretion.
- High levels may be caused by dehydration or shock, severe burns, hemolysis, diabetic ketoacidosis, and retention of potassium by the kidney.

SODIUM (NA)

(Serum, ISE (Indirect))

138

mmol/L

136 - 145

INTERPRETATION:

- Hypernatremia will be seen in dehydration, Cushing syndrome, central or nephrogenic diabetes insipidus with insufficient fluids, primary aldosteronism, lactic acidosis, azotemia, weight loss, nonketotic hyperosmolar coma.
- Hyponatremia occurs with nephrotic syndrome, cachexia, hypoproteinemia, intravenous glucose infusion, in congestive heart failure and other clinical entities. Serum sodium is a predictor of cardiovascular mortality in patients in severe congestive heart failure. Addison disease, hypopituitarism, cirrhosis, hypertriglyceridemia and psychogenic polydipsia.

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

DR. ADLEY MARK FERNANDES

M.D (Pathology)

Pathologist

Vyoma V. Shah

DR. VYOMA SHAH

M.D (Pathology)

Clinical Pathologist

Harshad Manikandan

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Laboratory Technician

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