LB-MED-305

Patient Name	:	Mr. SANDEEP GOUD GEENIKUNTLA SRINIVAS GOUD	**Sample UID No.**	:	4108569
Age / Gender	:	25 Y / Male	**Sample Collected On**	:	14-08-2025 16:49
Patient ID	:	QLD108107	**Registered On**	:	14-08-2025 17:18
Referred By	:	DR KEERTHANA	**Reported on**	:	14-08-2025 19:07
Referral Client	:	CITICARE MEDICAL CENTER(INSURANCE)	**External Patient ID**	:	43966
Emirates ID / Passport No	:	784200075553006	**Print Version**	:	V 1

Department of BIOCHEMISTRY

Investigation	Results	Flag	Units	Biological Reference Interval	Method
* C-REACTIVE PROTEIN (CRP)	0.8		mg/L	< 5	Particle enhanced immunoturbidimetric assay

Sample: Serum

Comments :

CLINICAL IMPLICATIONS:

1. CRP is the most sensitive acute phase reactant that can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgeryor neoplastic proliferation. CRP levels may predict future cardiovascular events and can be used as a screening tool.

2. The traditional test of CRP has added significance over the elevated ESR, which may be influenced by altered physiologic states. CRP tends to increase before rises in antibody titres and ESR level occurs. CRP levels also tend to decrease sooner than ESR levels.

3. The traditional test for CRP is elevated in rheumatic fever, RA, myocardial infarction, malignancy, bacterial and viral infections. The positive test indicates active inflammation but not its cause. In RA, the traditional test for CRP becomes negative with successful treatment and indicates that the inflammation has subsided.

4.High sensitive measurement of CRP (hs-CRP) are useful in assessing vascular inflammation and cardiovascular stratification. A single test for hs-CRP may not reflect an individual patient basal hs-CRP level, therefore follow up tests or serial measurements may be required in patients presenting with increased hs-CRP levels.

INTERFERING FACTORS: Haemolysed or lipemic sample may alter the results.

REFERENCE:

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]

2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

Note:

"The analytes with asterix (*) symbol are non-accredited parameters.".
"QLabs compliance with ISO 15189:2022 standards"

Vaishnav Jayamohan
Lab Technologist
DHA No. 87250933-002

Dr. Vidhya Mohan
Specialist Clinical Pathologist
Clinical Pathologist
DHA No. 23553203-004

Dr. Dheepa Manoharan
Medical Director
Specialist Microbiologist
DHA No. 00231751-004

QLABS Clinical Laboratory Off No 304, Carrera Building, Karama +971 4 578 2223 info@qlabsonline.com

Patient Name	:	Mr. SANDEEP GOUD GEENIKUNTLA SRINIVAS GOUD	**Sample UID No.**	:	EB4108569
Age / Gender	:	25 Y / Male	**Sample Collected On**	:	14-08-2025 16:49
Patient ID	:	QLD108107	**Registered On**	:	14-08-2025 17:18
Referred By	:	DR KEERTHANA	**Reported on**	:	15-08-2025 07:02
Referral Client	:	CITICARE MEDICAL CENTER(INSURANCE)	**External Patient ID**	:	43966
Emirates ID / Passport No	:	784200075553006	**Print Version**	:	V 1

Department of HEMATOLOGY

COMPREHENSIVE COMPLETE BLOOD COUNT

Investigation	Results	Flag	Units	Biological Reference Interval	Method
HEMOGLOBIN	13.7		g/dl	13-17	photometric
RBC COUNT	5.01		10^6/uL	4.5-5.5	Electrical Impedance
HEMATOCRIT	40.8	L	%	42-52	Calculation
MCV	81.4		fL	78-100	Calculation
MCH	27.3		pg	27-31	Calculation
MCHC	33.5		g/dl	31-35	Calculation
RDW	13.6		%	9.3-16	Calculation
RDW-SD	39.4		fL	38.9-49	Calculation
MPV	8	L	fL	8.8-12.5	Calculation
PLATELET COUNT	309		10^3/uL	150-400	Electrical Impedance
* PCT	0.2		%	0.01-9.99	Calculation
* PDW	16.3			0.1-99.9	Calculation
* NUCLEATED RBC (NRBC)^	0.02		/100 WBC		Flow Cytometry
* ABSOLUTE NRBC COUNT^	0		10^3/uL		Calculation
* EARLY GRANULOCYTE COUNT (EGC)^	0.34		%		Flow Cytometry
* ABSOLUTE EGC^	0.03		10^3/uL		Calculation
WBC COUNT	8.8		10^3/uL	4-11	Electrical Impedance
* Neutrophil	56.02		%	40-80	VCS-Method
* Lymphocyte	33.05		%	20-40	VCS-Method
* Eosinophil	4.09		%	1-8	VCS-Method
* Monocyte	5.77		%	2-10	VCS-Method
* Basophil	1.07		%	0-2	VCS-Method
* ABSOLUTE NEUTROPHIL COUNT	4.93		10^3/uL	1.5-7	Calculation
* ABSOLUTE LYMPHOCYTE COUNT	2.91		10^3/uL	1.5-4	Calculation
* ABSOLUTE MONOCYTE COUNT	0.51		10^3/uL	0-0.8	Calculation
* ABSOLUTE EOSINOPHIL COUNT	0.36		10^3/uL	0-0.6	Calculation
* ABSOLUTE BASOPHIL COUNT	0.09		10^3/uL	0-0.2	Calculation

Sample: EDTA Whole Blood

Note:

"The analytes with asterix (*) symbol are non-accredited parameters.".
"QLabs compliance with ISO 15189:2022 standards"

Ebin C Lorance
Lab Technologist

DHA No. 57146854-002

Dr. Vidhya Mohan
Specialist Clinical Pathologist
Clinical Pathologist
DHA No. 23553203-004

LB-MED-305

Patient Name	:	Mr. SANDEEP GOUD GEENIKUNTLA SRINIVAS GOUD	**Sample UID No.**	:	4108569
Age / Gender	:	25 Y / Male	**Sample Collected On**	:	14-08-2025 16:49
Patient ID	:	QLD108107	**Registered On**	:	14-08-2025 17:18
Referred By	:	DR KEERTHANA	**Reported on**	:	14-08-2025 19:07
Referral Client	:	CITICARE MEDICAL CENTER(INSURANCE)	**External Patient ID**	:	43966
Emirates ID / Passport No	:	784200075553006	**Print Version**	:	V 1

Department of IMMUNOLOGY

Investigation	Results	Flag	Units	Biological Reference Interval	Method
HIV I & II ANTIBODY AND P24 ANTIGEN	0.23 (Non Reactive)		COI	< 1.00 : Non-reactive ≥ 1.00 : Reactive	ECLIA

Sample: Serum

Interpretation Notes :

Specimens with COI values <1.00 are considered Nonreactive(NR) Specimens with COI values > OR equal to 1.00 are considered reactive®

CLINICAL IMPLICATIONS: 1. The method is a fourth generation assay which detects HIV1and 2/p24 antigen based on chemiluminescent microparticle immunoassay.The result does not distinguish between the detection of HIV p24 antigen,HIV-1 antibody,or HIV-2 antibody reactivity.Since the combo can detect the anti-HIV p24 antigen in the reagent ,thereby decreasing the seroconversion window and improving early detection of HIV infection. 2. A repeatedly reactive specimen should be investigated further with sensitive,supplemental HIV-specific tests,such as immunoblots,antigen tests,and HIV nucleic acid tests.HIV Ag/Ab combo and supplemental assay results should be interpreted in conjunction with the patients clinical presentation,history and other laboratory results. 3. Specimens which are repeatedly reactive on a fourth generation screening procedure but which test negative on the second step assay may either have a false positive result or be positive for p24 antigen only.The new algorithm is that the specimen is subjected to further qualitative RNA molecular assay.

REFERENCE:
1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU
3)Clinical microbiology procedures 4th edition AMY L LEBER

- END OF REPORT -

"QLabs compliance with ISO 15189:2022 standards"

Vaishnav Jayamohan
Lab Technologist
DHA No. 87250933-002

Dr. Vidhya Mohan
Specialist Clinical Pathologist
Clinical Pathologist
DHA No. 23553203-004

Dr. Dheepa Manoharan
Medical Director
Specialist Microbiologist
DHA No. 00231751-004

QLABS Clinical Laboratory Off No 304, Carrera Building, Karama +971 4 578 2223 info@qlabsonline.com