TATA 1mg | Labs
Tata 1mg Technologies Private Limited
Registered office: 2nd Floor, Plot No. B-225, Okhla Industrial Area, Phase-I, South Delhi, New Delhi-110020, Delhi
www.1mg.com/labs care@1mg.com CIN: U74140DL2015PTC279229
ISO 9001:2015
MC - 7802

PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897971 / 17007914	Report Date	: 19/May/2026 12:51PM
Sample Type	: WHOLE BLOOD-EDTA	Report Status	: Final Report

HAEMATOLOGY

COMPLETE HAEMOGRAM

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	12.6	g/dL	12.0 - 15.0	Spectrophotometry (Cyanide-free)
RBC	4.09	10^6/cu.mm	3.8 - 4.8	Impedence
HCT	37.1	%	36 - 46	Calculated
MCV	90.6	fL	83 - 101	Calculated
MCH	30.7	pg	27 - 32	Calculated
MCHC	33.9	g/dL	31.5 - 34.5	Calculated
RDW-CV	**15.7**	%	11.5-14	Calculated
Total Leucocyte Count	6.42	10^3/µL	4 - 10	Impedance
Differential Leucocyte Count				
Neutrophils	47.2	%	40-80	DHSS/Microscopy
Lymphocytes	**45.3**	%	20-40	DHSS/Microscopy
Monocytes	4.9	%	2-10	DHSS/ Microscopy
Eosinophils	2.4	%	1-6	DHSS/Microscopy
Basophils	0.2	%	0-2	DHSS/ Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	3.03	10^3/µL	2 - 7	Calculated
Absolute Lymphocyte Count	2.91	10^3/µL	1-3	Calculated
Absolute Monocyte Count	0.31	10^3/µL	0.2 - 1	Calculated
Absolute Eosinophil Count	0.15	10^3/µL	0.02 - 0.5	Calculated
Absolute Basophil Count	**0.01**	10^3/µL	0.02-0.1	Calculated
Platelet Count	236	10^3/µL	150 - 410	Impedance/Microscopy
MPV	10.4	fL	6.5 - 12	Calculated
PDW	13.1	fl	9-17	Calculated

Comment:

As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.
DHSS : Double Hydrodynamic Sequential System Flowcytometry
Calculated parameters are either derived from Impedence measure, RBC pulse measurement, RBC/platelet histograms or formula derived.

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: JCMR 5830/18

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HAEMATOLOGY

COMPLETE HAEMOGRAM

Test Name	Result	Unit	Bio. Ref. Interval	Method
Erythrocyte Sedimentation Rate				
Erythrocyte Sedimentation Rate	19	mm/hr	0-20	Modified Westergren

Comment:

- ESR provides an index of progress of the disease and is widely used as an indicator of inflammation, infection, trauma, or malignant diseases. Changes are more significant than a single abnormal test
- It is specifically indicated to monitor the course or response to the treatment of diseases like rheumatoid arthritis, tuberculosis bacterial endocarditis ,acute rheumatic fever ,Hodgkins disease,temporal arthritis , and systemic lupus erythematosis; and to diagnose and monitor giant cell arteritis and polymyalgia rheumatica.
- An elevated ESR may also be associated with many other conditions, including autoimmune disease, anemia, infection,malignancy,pregnancy, multiple myeloma, menstruation, and hypothyroidism.
- Although a normal ESR cannot be taken to exclude the presence of organic disease, its rate is dependent on various physiologic and pathologic factors.
- The most important component influencing ESR is the composition of plasma. High level of C-Reactive Protein, fibrinogen, haptoglobin, alpha-1antitrypsin, ceruloplasmin and immunoglobulins causes the elevation of Erythrocyte Sedimentation Rate.
- Drugs that may cause increase ESR levels include: dextran, methyldopa, oral contraceptives, penicillamine, procainamide, theophylline, and Vitamin A. Drugs that may cause decrease levels include: aspirin, cortisone, and quinine

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HAEMATOLOGY

DIABETES SCREENING

Test Name	Result	Unit	Bio. Ref. Interval	Method
HbA1c (Glycosylated Hemoglobin)				
Glycosylated Hemoglobin (HbA1c)	**6.3**	%	4-5.6	HPLC (NGSP certified)
Estimated average glucose (eAG)	134.11	mg/dL		Calculated

Comment:

Interpretation: HbA1c%

≤5.6	Normal
5.7-6.4	At Risk For Diabetes
≥6.5	Diabetes

Adapted from American Diabetes Association.

Comments:

A 3 to 6 monthly monitoring is recommended in diabetics. People with diabetes should get the test done more often if their blood sugar stays too high or if their healthcare provider makes any change in the treatment plan. HbA1c concentration represent the integrated values for blood glucose over the preceding 8-12 weeks and is not affected by daily glucose fluctuation, exercise & recent food intake.

Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.

Factors that interfere with HbA1c Measurement: Hemoglobin variants, elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements.

Factors that affect interpretation of HbA1c Measurement: Any condition that shortens erythrocyte survival or decrease mean erythrocyte age (e. g., recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used. Iron deficiency anemia is associated with higher HbA1c.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1c result does not correlate with the patient's blood glucose levels.

- HPLC - High performance liquid chromatography

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Barcode ID/Order ID	: D31897973 / 17007914	Report Date	: 19/May/2026 11:35AM
Sample Type	: Fluoride Plasma F	Report Status	: Final Report

BIOCHEMISTRY

DIABETES SCREENING

Test Name	Result	Unit	Bio. Ref. Interval	Method
FBS (Fasting Blood Sugar)				
Glucose - Fasting	95	mg/dL	70 - 99	Hexokinase

Comment:

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes. IGT (2 hrs Post meal), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes

Plasma Glucose Goals	For people with Diabetes
Before meal	70-130 mg/dL
2 Hours after meal	Less than 180 mg/dL
HbA1c	Less than 7%

NABL certificate and scope

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Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipid Profile				
Cholesterol - Total	153	mg/dL	Low (desirable): < 200 mg/dL Moderate (borderline) 200–239 mg/dL High: >/= 240 mg/dL	CHOD-POD
Triglycerides	**168**	mg/dL	Normal: <150, Borderline: 150 - 199, High:200-499, Very High>=500	GPO
Cholesterol - HDL	**40**	mg/dL	High risk <50mg/dL Low risk>=50mg/dL	Accelerator Selective Detergent
Cholesterol - LDL	79	mg/dL	Desirable: <100 Above desirable: 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : >=190	Calculated
Cholesterol- VLDL	**34**	mg/dL	<30	Calculated
Cholesterol : HDL Cholesterol	3.8	Ratio	Desirable : 3.0-4.0 High risk : >4	Calculated
LDL : HDL Cholesterol	1.99	Ratio	Desirable : 2.0-2.5 High risk : >3.0	Calculated
Non HDL Cholesterol	113	mg/dl	Desirable:< 130, Above Desirable:130 - 159, Borderline High:160 - 189, High:190 - 219, Very High: >= 220	Calculated

Comment:

●Lipid results show analytical and biological variation; repeat testing may be recommended before diagnosis or treatment

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BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method

decisions.

●Indians lie at high risk of developing early (a decade earlier than western populations) and more severe cardiovascular disease (ASCVD); higher mortality. Dyslipidemia (abnormal lipid profile) affects nearly 80% of population.

●**Total cholesterol** is the sum of all cholesterol in the blood, including HDL, LDL, VLDL, and remnants.

●**LDL Cholesterol (LDL-C**), is the main "bad" cholesterol that contributes to plaque buildup, increasing the risk of heart disease and stroke, typically calculated by the Friedewald formula. Direct LDL-C measurement by homogeneous enzymatic assays carried out when triglycerides >400 mg/dL or dysbetalipoproteinemia.

●**High-density lipoprotein (HDL**) or "good" cholesterol is anti-atherogenic (protective). Low HDL-C is a cardiovascular risk factor; seen in almost two-third of Indians. Values above 60 mg/dl are considered protective.

●**Triglyceride (TG)** are a key driver of CVD. Indians are especially prone to atherogenic dyslipidemia—high TG, low HDL-C, and high LDL-C—closely linked to diabetes, metabolic syndrome, and insulin resistance; making TG management crucial.

●**Non-HDL-Cholesterol (non-HDL-C)** Non-HDL-C measures all plaque-forming lipoproteins and is vital to monitor in high-TG patients (e.g., diabetics, obese) and those on statin therapy.

●**Lipid Association of India (LAI-2020) recommends:-**

- Screening of all Indians above the age of 20 years for CVD risk factors, esp. lipid profile.
- Identification of Major Risk factors: Age (male ≥45 years, female ≥55 years); Family h/o heart disease at younger age (<55 yrs in males, <65 yrs in female or before menopause), current smoking/tobacco use, High blood pressure, Low HDL (males <40 mg/dl and females <50mg/dl).
- Fasting not mandatory; both fasting and non-fasting lipid profiles are useful for screening in Indian patients.
- LAI identifies both LDL-C and non-HDL-C as risk factors and recommends LDL-C, non-HDL-C and Apo-B as targets of lipid-lowering therapy.
- Lifestyle changes are the first-line approach for managing and preventing dyslipidemia. Treatment in low-risk individuals is initiated only after 3 months of unsuccessful lifestyle modification.
- Testing for Apolipoprotein B(Apo-B), hsCRP, Lp(a) should be considered for patients in moderate risk group.

Treatment targets for lipid-lowering therapy for various ASCVD risk groups

Risk Group	Treatment targets		
	LDL-C, mg/dL (primary target)	Non-HDL-C, mg/dL (co-primary target)	Apo-B, mg/dL (secondary target)
Low-risk group	<100	<130	<90
Moderate-risk group	<100 (optional <70)	<130 (optional <100)	<90
High-risk group	<70	<100	<80
Very high-risk group	<50	<80	<65
Extreme-risk group- category A	<50 (optional ≤30)	<80 (optional ≤60)	<65
Extreme-risk group- category B	≤30	≤60	<50
Extreme-risk group- category C	10-15	40-45	-

Source: LAI (2024) Consensus Statement IV

●Per **NCEP Expert Panel (2011) guidelines,** universal dyslipidemia screening is advised at 9–11 years and repeated at 17–21 years. Screening before age 2 yrs is not recommended; from age 2 onward, selective screening is done for children with a family history of premature CVD or risk factors such as obesity, diabetes, or hypertension.

Note: Biological Reference Interval as per National Cholesterol Education Program (NCEP) ATP III and LAI guidelines

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BIOCHEMISTRY

KIDNEY FUNCTION TEST & LIVER FUNCTION TEST

Test Name	Result	Unit	Bio. Ref. Interval	Method
LIVER FUNCTION TEST				
Liver Function Test				
Bilirubin-Total	0.37	mg/dL	0.2 – 1.1	Vanadate oxidation
Bilirubin-Direct	0.11	mg/dL	0.0-0.3	Vanadate oxidation
Bilirubin-Indirect	0.26	mg/dL	0.2-0.8	Calculated
Protein, Total	7.30	g/dL	5.7–8.2	Biuret
Albumin	4.30	g/dL	3.2-4.8	BCG Dye Binding
Globulin	3.0	g/dL	2.3 - 4.1	Calculated
A/G Ratio	1.43	Ratio	0.8 - 1.9	Calculated
SGOT (Aspartate Aminotransferase)	**36**	U/L	<34	Modified IFCC
SGPT (Alanine Transaminase)	37	U/L	10-49	Modified IFCC
SGOT/SGPT	0.97	Ratio		Calculated
Alkaline Phosphatase	113	U/L	46-116	IFCC Standardization
Gamma Glutamyltransferase (GGT)	13	U/L	<38	Modified IFCC

Comment:

- Raised ALT and AST indicate hepatocellular damage (e.g. viral or drugs etc). ALT is more liver-specific while AST is also found in heart, skeletal muscle, and kidney. Mild elevation (less than twice normal) often resolves on its own. Fatty liver disease (especially with metabolic syndrome) is a common cause in asymptomatic cases. Certain drugs (paracetamol, statins), herbal supplements, energy drinks, and antibiotics may also affect liver function.
- SGOT/SGPT Ratio: Typically <1 in healthy individuals (vary between 0.7-1.4; higher in women than men). High SGPT (ratio <1) seen in acute or chronic hepatitis, autoimmune disorders, medications, toxins while ratio >1 indicates alcoholic hepatitis, cirrhosis, metastasis or non-hepatic issues (hemolytic diseases, CVS disorders).
- Elevated Alkaline Phosphatase and GGT: Suggest cholestatic diseases (e.g. bile duct obstruction, primary biliary cirrhosis etc.) and can also be due to bone disease, pregnancy, chronic renal failure, malignancy, and congestive heart failure.
- High Bilirubin: Indicates jaundice due to increased RBC breakdown, liver damage (e.g., infections, toxins), or cholestasis (e.g., gallstones, tumors).
- High Protein Levels: Seen in dehydration (e.g., severe vomiting, diarrhea) or increased production (e.g., inflammation, hematopoietic neoplasms). Low protein and albumin: Result from impaired synthesis (liver disease), decreased intake, tissue damage, malabsorption, or increased renal excretion.

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BIOCHEMISTRY

KIDNEY FUNCTION TEST & LIVER FUNCTION TEST

Test Name	Result	Unit	Bio. Ref. Interval	Method
Kidney Function Test.				
Blood Urea Nitrogen	20	mg/dL	9.0-23	Urease with GLDH
Urea	42.80	mg/dL	19.26-49.22	Calculated
Creatinine	0.84	mg/dL	0.55-1.02	Alkaline picrate-kinetic
Uric Acid	5.8	mg/dL	2.7-6.1	Uricase/Peroxidase
Sodium	142	mEq/L	136-145	Indirect ISE
Potassium	3.62	mEq/L	3.5-5.1	Indirect ISE
Chloride	105.0	mEq/L	98-107	Indirect ISE
BUN/Creatinine Ratio	23.8	Ratio	12:1 - 20:1	Calculated

Comment:

BUN is directly related to protein intake and nitrogen metabolism and inversely related to the rate of excretion of urea.Blood urea nitrogen (BUN) levels reflect the balance between the production and excretion of urea. Increased levels are seen in renal failure (acute or chronic), urinary tract obstruction, dehydration, shock, burns, CHF, GI bleeding, nephrotoxic drugs. Decreased levels are seen in hepatic failure, nephrotic syndrome, cachexia (low-protein and high-carbohydrate diets).

Urea is a non-proteinous nitrogen compound formed in the liver from ammonia as an end product of protein metabolism. Urea diffuses freely into extracellular and intracellular fluid and is ultimately excreted by the kidneys. Increased levels are found in acute renal failure, chronic glomerulonephritis, congestive heart failure, decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypovolemia, ketoacidosis, muscle wasting from starvation, neoplasms, pyelonephritis, shock, urinary tract obstruction, nephrotoxic drugs. Decreased levels are seen in inadequate dietary protein, low-protein/high-carbohydrate diet, malabsorption syndromes, pregnancy, severe liver disease, certain drugs.

Creatinine is catabolic product of creatinine phosphate, which is excreted by filtration through the glomerulus and by tubular secretion. Creatinine clearance is an acceptable clinical measure of glomerular filtration rate (GFR). Increased levels are seen in acute/chronic renal failure, urinary tract obstruction, hypothyroidism, nephrotoxic drugs, shock, dehydration, congestive heart failure, diabetes. Decreased levels are found in muscular dystrophy.

BUN/Creatinine ratio (normally 12:1–20:1) is decreased in acute tubular necrosis, advanced liver disease, low protein intake, and following hemodialysis. BUN/Creatinine ratio is increased in dehydration, GI bleeding, and increased catabolism.

Uric acid levels show diurnal variation. The level is usually higher in the morning and lower in the evening. Increased levels are seen in starvation, strenuous exercise, malnutrition, or lead poisoning, gout, renal disorders, increased breakdown of body cells in some cancers (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure, pre-eclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone (PTH), certain drugs, foods that are very high in purines - such as organ meats, red meats, some seafood and beer. Decreased levels are seen in liver disease, Wilson's disease, Syndrome of inappropriate antidiuretic hormone (SIADH), certain drugs.

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BIOCHEMISTRY

PARATHYROID PROFILE

Test Name	Result	Unit	Bio. Ref. Interval	Method
Calcium				
Calcium	8.9	mg/dL	8.7-10.4	Arsenazo III

Comment:

Increased in: Hyperparathyroidism primary and secondary, Acute and chronic renal failure, Following renal transplantation, Osteomalacia with malabsorption, Acute osteoprosis, Malignant tumours (specially of breast, lung and kidney), Drugs: Vit. D and A intoxication, Diuretics, estrogen, androgen, tamoxifen, lithium

Decreased in: Hypoparathyroidism, Surgical and Idiopathic, Pseudohypoparathyroidism, Chronic renal disease with uremia and phophate retention, Malabsorption of Calcium and Vit.D, obstructive jaundice, Bone Disease (Osteomalacia and rickets), Drugs: Cancer chemotherapy drugs, calcitonin, loop-actives diuretics, Hypomagnesemia,Hypoalbuminemia

Phosphorus, Serum				
Phosphorus	5.10	mg/dl	2.4 - 5.1	Phosphomolybdate

Comment:

Phosphate metabolism is under the regulation of PTH, Vitamin D metabolites, and Fibroblast growth factor-23.
Serum phosphate concentrations are about 50% higher in infants than in adults and decline throughout childhood as a consequence of the ability of growth hormone to increase the renal phosphate threshold.

Increased in:

Decreased Renal filtraton (Acute or chronic renal failure) or increased reabsorption (e.g., hypoparathyroidism)
Increased Phosphate load (e.g., Oral or iv administration, Phosphate-containing laxatives or enemas, Vitamin D intoxication)
Cell Lysis (e.g., hemolysis, leukemias, chemotherapy, rhabdomyolysis)
Bone disease (e.g., healing fractures, multiple myeloma, Paget disease, osteolytic tumors)
Genetic (e.g., Hypoparathyroidism, Tumoral calcinosis)

Decreased in:

Intracellular Shift (e.g., Oral or intravenous Glucose, Insulin, Diabetic ketoacidosis, Respiratory alkalosis, Alcoholism, Severe burns)
Lowered Renal Phosphate Threshold (e.g., Primary or secondary hyperparathyroidism, Renal tubular defects)
Decreased Intestinal Absorption (Malabsorption syndrome, Vitamin D deficiency) or increased loss (Vomiting, Diarrhea)
Drugs (e.g., Salicylate, Paracetamol, Estrogens, Diuretics, Bisphosphonates, Anticonvulsants, Phosphate binding antacids, Antiviral drugs etc)

Note:

Because a significant diurnal variation in plasma phosphate has been reported, fasting morning specimens are recommended. Levels are influenced by dietary intake, meals, and exercise.

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Iron Studies, Comprehensive				
Iron Serum	**46**	µg/dL	50-170	Ferrozine
Total Iron Binding Capacity (TIBC)	299	µg/dL	250-460	Calculated
Unsaturated Iron Binding Capacity	253	µg/dL	120-470	Ferene
Transferrin saturation	**15.38**	%	16-50	Calculated
Ferritin	50.50	ng/mL	10-291	CLIA

Comment:

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron is seen in iron deficiency and anaemia of chronic disorders.
Increased iron concentration are seen in hemolytic anaemias, hemochromatosis and acute liver disease. Serum Iron alone is unreliable due to considerable physiologic diurnal variation in the results with highest values in the morning and lowest values in the evening as well as variation in response to iron therapy .

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. Increased levels of TIBC suggest that total iron body stores are low, increased concentration may be the sign of Iron deficiency anaemia, polycythemia vera ,and may occur during the third trimester of pregnancy. Decreased levels may be seen in hemolytic anaemia, hemochromatosis, chronic liver disease, hypoproteinemia ,malnutrition.

Unsaturated Iron Binding Capacity (UIBC) is increased in low iron state and decreased in high iron concentration such as hemochromatosis. In case of anaemia of chronic disease the patient may be anaemic but has adequate iron reserve and a low uIBC.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

*Please note change in BRI of Ferritin.

High Sensitive CRP				
High sensitivity CRP	0.64	mg/L	Healthy Individuals: <= 3.0 Low Risk: < 1.0 Average Risk: 1.0 to 3.0 High Risk: > 3.0	Immunoturbidimetriy

Comment:

Note:

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: JCMR 5830/18

Scan for digital copy

PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 19/May/2026 11:49AM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method

1. Patients with persistently unexplained hs-CRP levels above 10 mg/L should be evaluated for other non-cardiovascular etiologies or sources of infection and inflammation.
2. For cardiovascular risk assessment, hs-CRP should ideally be measured twice, two weeks apart, and the average value is used (accounts for within-subject variability), in metabolically stable patient.

Interpretation:

- High-sensitivity C-reactive protein (hs-CRP) serves as a biomarker for cardiovascular risk assessment, typically evaluated in conjunction with the lipid profile.
- The American Heart Association and US Centers for Disease Control and Prevention have defined risk groups as follows:* <1.0 Low Risk; 1.0 - 3.0 - Average Risk; >3.0 High Risk
- Both hs-CRP and CRP measure the same protein, but hs-CRP is more sensitive and used for cardiovascular risk assessment. For accurate interpretation, testing should be done when the patient is in a stable, healthy state.
- Recent illness, infection, tissue injury, or other sources of inflammation may elevate hs-CRP and lead to an overestimation of cardiovascular risk; It should not be used in individuals with chronic inflammatory conditions (e.g., arthritis), as results may be misleading.
- Women on hormone replacement therapy have been shown to have elevated hs-CRP levels.
- Anti-inflammatory drugs (e.g., aspirin, ibuprofen, naproxen) and statins can lower CRP levels.

*Source: Pearson et al; Markers of inflammation and cardiovascular disease; Circulation, 107 (3) (2003)

C-Reactive Protein Quantitative

C-Reactive Protein (Quantitative)	2.30	mg/L	0 - 3.3	Particle Enhanced turbidimetric immunoassay

Comment:

•C-Reactive Protein [CRP] is an acute phase reactant ,hepatic secretion of which is stimulated in response to inflammatory cytokines.
•CRP is a very sensitive but nonspecific marker of inflammation and infection.
•The CRP test is useful in patient with Inflammatory bowel disease, arthritis, Autoimmune diseases, Pelvic inflammatory disease (PID), tissue injury or necrosis and infections.
•CRP levels can be elevated in the later stages of pregnancy as well as with use of birth control pills or hormone replacement therapy i.e. estrogen. Higher levels of CRP have also been observed in the obese.
•As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, he intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia.

NABL certificate and scope

This test has been performed at
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Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
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Reg. No: JCMR 5830/18

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 20/May/2026 11:57AM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Magnesium				
Magnesium	2.07	mg/dL	1.30-2.70	Xylidyl blue

Comment:

Magnesium (Mg) is an important cation essential for the function of more than 300 cellular enzymes.Total body Mg depends on GI absorption and renal excretion.50 - 60% of body magnesium content is stored in the bones.

Increased levels (Hypermagnesemia) : Acute & chronic renal failure, Addison's disease, Diuretics, antacids & laxative use, Hypothyroidism, Elderly diabetics.

Decreased levels (Hypomagnesemia) : Chronic nephritis, Acute pancreatitis, Alcoholic cirrhosis.

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla
Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 56096

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897973 / 17007914	Report Date	: 20/May/2026 10:51AM
Sample Type	: FLUORIDE PLASMA	Report Status	: Final Report

BIOCHEMISTRY

HOMA IR, INSULIN RESISTANCE INDEX

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glucose - Fasting	95	mg/dL	70-99	Hexokinase/G-6-PDH

Fasting Plasma Glucose (mg/dL)	2 hr plasma Glucose (mg/dL)	Diagnosis
99 or below	139 or below	Normal
100 to 125	140 to 199	Pre-Diabetes (IGT)
126 or above	200 or above	Diabetes

Reference : American Diabetes Association

PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 19/May/2026 12:51PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Thyroid Profile Free				
Free T3	2.82	pg/mL	2.3-4.2	CLIA
Free T4	1.11	ng/dL	0.89-1.76	CLIA
Thyroid Stimulating Hormone - Ultrasensitive	4.526	uIU/ml	0.55-4.78	CLIA

Comment:

- Below mentioned are the guidelines for pregnancy related reference ranges for TSH, free T3 & free T4.

Pregnancy			
	TSH (µIU/mL) (As per American Thyroid Association)	FT3 (pg/mL)	FT4(ng/dL)
1st trimester	0.1-2.5	2.0 - 3.8	0.7- 2.0
2nd trimester	0.2-3.0	2.0 - 3.8	0.5-1.6
3rd trimester	0.3-3.0	2.0 - 3.8	0.5-1.6

- TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm .
- The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.
- TSH is secreted in a dual fashion: Intermittent pulses constitute 60-70% of total amount, background continuous secretion is 30-40%.These pulses occur regularly every 1-3 hrs.
- Serum TSH level changes significantly in response to even minor changes in thyroid hormones.
- The determination of free T3 & free T4 has the advantage of being independent of changes in the concentrations and binding properties of the binding proteins.
- For diagnostic purposes, results should be used in conjunction with other data; e.g., symptoms, results of other thyroid tests, clinical impressions, etc.

TSH	T3 /FT3	T4/FT4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 19/May/2026 12:51PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism	

NABL certificate and scope

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897969 / 17007914	Report Date	: 19/May/2026 11:35AM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

PARATHYROID PROFILE

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin D (25-OH)				
Vitamin D (25-OH)	42.9	ng/ml	Deficiency:< 20, Insufficiency:20-29, Sufficiency:30 - 100, Toxicity possible:> 100	CLIA

Comment:

- Vitamin D is a fat-soluble steroid prohormone involved in the intestinal absorption of calcium and the regulation of calcium homeostasis.
- Two forms of vitamin D are biologically relevant - vitamin D3 (Cholecalciferol) and vitamin D2 (Ergocalciferol).
- Both vitamins D3 and D2 can be absorbed from food but only an estimated 10-20perc. of vitamin D is supplied through nutritional intake.
- Vitamin D is converted to the active hormone 1,25-(OH)2-vitamin D (Calcitriol) through two hydroxylation reactions. The first hydroxylation converts vitamin D into 25-OH vitamin D and occurs in the liver. The second hydroxylation converts 25-OH vitamin D into the biologically active 1,25-(OH)2-vitamin D and occurs in the kidneys as well as in many other cells of the body.
- Most cells express the vitamin D receptor and about 3perc. of the human genome is directly or indirectly regulated by the vitamin D endocrine system.
- The major storage form of vitamin D is 25-OH vitamin D and is present in the blood at up to 1,000 fold higher concentration compared to the active 1,25-(OH)2-vitamin D. 25-OH vitamin D has a half-life of 2-3 weeks vs. 4 hours for 1,25-(OH)2-vitamin D. Therefore, 25-OH vitamin D is the analyte of choice for determination of the vitamin D status.
- Risk factors for vitamin D deficiency include low sun exposure, inadequate intake, decreased absorption, abnormal metabolism, vitamin D resistance and and liver or kidney diseases.
- Vitamin D deficiency is a cause of secondary hyperparathyroidism and diseases resulting in impaired bone metabolism (like rickets, osteomalacia).
- Recently, many chronic diseases such as cancer, high blood pressure, osteoporosis and several autoimmune diseases have been linked to vitamin D deficiency.
- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D

Utility Quantitative determination of 25-hydroxyvitamin D (25-OH vitamin D).

*__CMIA__-Chemiluminescent Microparticle Immunoassay /__CLIA__-Chemiluminescent immunoassay.

NABL certificate and scope

This test has been performed at
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Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

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Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897969 / 17007914	Report Date	: 19/May/2026 11:35AM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

PARATHYROID PROFILE

Test Name	Result	Unit	Bio. Ref. Interval	Method

NABL certificate and scope

This test has been performed at
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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 19/May/2026 12:51PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin B12				
Vitamin B12	361.0	pg/ml	211-911	CLIA

Comment:

- **Vitamin B12** along with **folate** is essential for DNA synthesis and myelin formation.
- **Decreased levels** are seen in anaemia, term pregnancy, vegetarian diet, intrinsic factor deficiency, partial gastrectomy/ileal damage, celiac disease, oral contraceptive use, parasitic infestation, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advanced age.
- **Increased levels** are seen in renal failure, hepatocelluar disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills.

*__CMIA__-Chemiluminescent Microparticle Immunoassay /__CLIA__-Chemiluminescent immunoassay.

Homocysteine				
Homocysteine	**17.19**	umol/L	3.7-13.9	CLIA

Comment:

Interpertation:
Increased levels are seen in deranged Vit B12 metabolism and form an independent marker for risk of thromboembolic episodes in coronary artery disease (CAD)

Clinical Utility:
•Determine risk for heart disease, stroke and peripheral arterial blood vessel disease.
•Identify vitamin B12 deficiency or folic acid deficiency.
•Identify homocystinuria

The recommended use of Homocysteine (HCY) to assess risk factor for CAD are
•It is specially useful in young CAD patients (<40 years)
•In known cases of CAD,high HCYlevels should be used as a prognostic marker for CAD events and mortality.
•CAD patients with HCY levels >15 umol/L belong to high risk group.
•Increased HCY levels with low vitamin concentrations should be handled as a potential vitamin deficiency case .

High values of HCY are found in dietary deficiency of folic acid, vitamin B6, or vitamin B12, homocystinuria, chronic liver and renal failure,post menopausal state , hypothyroidism, Alzheimer's disease,vaious neoplastic disease like cancers of ovary or breast and Acute lymphoblastic leukemia,drugs (anti-anticonvulsants, antibiotics, theophylline, birth control pills, and tamoxifen),alcoholism, smoking or tobacco usage.
Low values may be caused by some medicines or vitamins such as folic acid, vitamin B12, or niacin.

• Please note test values may vary depending on the assay method used.

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: JCMR 5830/18

Scan for digital copy

PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 19/May/2026 12:51PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method

*__CMIA__-Chemiluminescent Microparticle Immunoassay /__CLIA__-Chemiluminescent immunoassay.

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi
Jharkhand - 834002

Dr. Luna Sinha
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: JCMR 5830/18

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897969 / 17007914	Report Date	: 20/May/2026 12:38PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

HOMA IR, INSULIN RESISTANCE INDEX

Test Name	Result	Unit	Bio. Ref. Interval	Method
HOMA IR, Insulin Resistance Index				
Insulin (fasting)	6.71	µU/mL	3.0-25.0	CLIA
Beta Cell Function (%B)	78.00	%		
Insulin Sensitivity (%S)	112.90	%		
HOMA IR	0.89		<2.5	Calculated

Comment:

Homeostatic model assessment (HOMA) is a method for assessing beta-cell function (%B)and insulin sensitivity (%S) from fasting glucose and insulin concentrations. HOMA can be used to track changes in insulin sensitivity and beta-cell function to examine the natural history of diabetes. Insulin sensitivity is reduced in normal subjects having first-degree relative type 2 diabetes compared with control subjects. Changes in beta-cell sensitivity in subjects on insulin secretagogues may be useful in determining beta-cell function over a period.

Note:

- This assay cannot be used to assess beta-cell function in those taking exogenous insulin. In such patients HOMA-IR, C-peptide Model is recommended.
- The HOMA IR calculator version 2.2 accepts values only in the following validated ranges, Insulin (2.9- 57.6 µU/mL) and Glucose (54.1-450.5 mg/dL).

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla
Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 56096

Scan for digital copy

PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 20/May/2026 12:58PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Anti Cyclic Citrullinated Peptide				
(Anti-CCP)	0.90	U/mL	negative : < 5.0 U/mL positive : >= 5.0 U/mL	CMIA

Comment:

- Anti-CCP is semi quantitative determination of Immunoglobulin G auto antibodies specific to Cyclic citrullinated peptide.
- It is useful in the diagnosis of Rheumatoid arthritis(RA), with high specificity, presence early in the disease process and ability to identify patients who are likely to have severe disease and irreversible change.
- False positive results are uncommon. Up to 30% patient with seronegative Rheumatoid arthritis also show Anti-CCP antibodies.
- The sensitivity of this assay is 70.6% and specificity is 98.2%.
- The value of Anti-CCP in Juvenile arthritis patients has not been determined.
- Anti CCP antibodies are detected in approximately 50-60% patient of Rheumatoid arthritis usually after 3-6 months of symptoms.
- Early Rheumatoid arthritis patients with Anti-CCP positivity may develop a more erosive form of the disease as compared with Anti-CCP negative patients.
- It can be used to differentiate elderly onset Rheumatoid arthritis from Polymyalgia rheumatica and erosive SLE.

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla
Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 56096

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 20/May/2026 12:55PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

ANTI THYROID ANTIBODIES PANEL

Test Name	Result	Unit	Bio. Ref. Interval	Method
Anti Thyroglobulin Antibody				
Anti Thyroglobulin Antibody (Anti-Tg)	< 3.00	IU/mL	< 4.11	CMIA

Comment:

- Autoantibodies to thyroglobulin (Anti Tg) are often present in patients with autoimmune thyroid disease.It may be found <10-15% of the normal population at low levels,during pregnancy and in patients with non-thyroidial illnesses, such as inflammatory rheumatic diseases. They are especially useful in patients presenting with subclinical hypothyroidism.

Clinical Utility
- Diagnosis of autoimmune thyroid disease and its separation from other causes of thyroiditis.
- Investigation of the cause of goitre.
- Follow up of deranged thyroid hormones.
- Evaluation of thyroid involvement in non thyroid related autoimmune diseases like SLE or RA.
- Evaluation of cases of pregnancy with autoimmune thyroid disorder like Hashimoto's thyroiditis, Grave's Disease, etc.
- Assessment of risk of foetal involvement in case of pregnancy with thyroid dysfunction.
- As a part of assessment of infertility.

Increased levels:
- Mild to moderate- in many thyroid and autoimmune disorders such as thyroid cancer, type I diabetes, rheumatoid arthritis, pernicious anaemia and autoimmune collagen vascular disease.
- Significantly increased- Hashimoto's thyroiditis and Grave's disease.
- Higher levels also seen women and with increasing age.

Note:
- Rising levels may be more significant than stable levels.
- Thyroglobulin antibodies can interfere with the assay of thyroglobulin as a cancer marker.
- Serial testing for monitoring should be done by the same laboratory using the same methodology.
- For diagnostic purposes, anti-Tg results should be used in conjunction with clinical information and other test results.
- Test values may vary depending on the assay method used.
- CMIA - Chemiluminescent Microparticle Immunoassay

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla
Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897970 / 17007914	Report Date	: 20/May/2026 01:06PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

ANTI THYROID ANTIBODIES PANEL

Test Name	Result	Unit	Bio. Ref. Interval	Method
Anti-TPO Antibody (Anti-Thyroid Peroxidase Antibody)				
Anti-Thyroid Peroxidase (Anti-TPO)	< 3.00	IU/mL	< 5.61	CMIA

Comment:

Anti Thyroid Peroxidase (Anti-TPO) are autoantibodies directed against the thyroid peroxidase enzyme,which catalyses iodine oxidation &iodination reactions in the thyroid .They may be found in < 10-15% of the normal population at low levels, during pregnancy & in patients with non-thyroidal illnesses, such as the inflammatory rheumatic diseases.

Clinical utility:

- Diagnosis of autoimmune thyroid disease and its separation from other causes of thyroiditis.
- Investigation of the cause of goitre.
- Follow up of deranged thyroid hormones.
- Evaluation of thyroid involvement in non thyroid related autoimmune diseases like SLE or RA.
- Evaluation of cases of pregnancy with autoimmune thyroid disorder like Hashimoto's thyroiditis, Grave's Disease, etc.
- Assessment of risk of foetal involvement in case of pregnancy with thyroid dysfunction.
- As a part of assessment of infertility.

Increased levels:

- Mild to moderate- in many thyroid and autoimmune disorders such as thyroid cancer, type I diabetes, rheumatoid arthritis, pernicious anaemia and autoimmune collagen vascular disease.
- Significantly increased- Hashimoto's thyroiditis and Grave's disease.
- Higher levels are also seen in women and with increasing age.

Note:

- Rising levels may be more significant than stable levels.
- Serial testing for monitoring should be done by the same laboratory using the same methodology.
- For diagnostic purposes, antibodies results should be used in conjunction with clinical information and other test results.
- Test values may vary depending on the assay method used.
- CMIA - Chemiluminescent Microparticle Immunoassay

NABL certificate and scope

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla Industrial Estate, New Delhi, Delhi 110020

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897972 / 17007914	Report Date	: 20/May/2026 11:01AM
Sample Type	: EDTA Plasma	Report Status	: Final Report

IMMUNOLOGY

PARATHYROID PROFILE

Test Name	Result	Unit	Bio. Ref. Interval	Method
Intact Parathyroid Hormone				
Parathyroid Hormone	78.60	pg/mL	18.4–80.1	CLIA

Comment:

- Test results should be interpreted in conjunction with serum calcium and phosphorous levels, and clinical findings.
- Elevated PTH with normal serum calcium levels may be indicative of secondary causes of hyperparathyroidism like Vitamin D deficiency. It may not always be indicative of primary hyperparathyroidism.
- PTH is secreted in a pulsatile manner with an overall circadian rhythm characterized by a nocturnal rise.

High PTH levels may be caused by:

- Vitamin D deficiency.
- Parathyroid gland hyperplasia or parathyroid tumor.
- Low level of calcium in the blood which may be caused by renal disease, renal failure, severe vitamin D deficiency or inability of the intestines to absorb calcium from food.
- Some drugs (lithium, furosemide, rifampin, anticonvulsants, thiazide diuretics, phosphates).

Low PTH levels may be caused by:

- Damage to the parathyroid gland which can by caused by neck surgery or radiation treatments.
- Rare diseases such as sarcoidosis or histiocytosis X.
- An overdose of vitamin D or calcium.
- Cancers such as lymphoma or multiple myeloma.
- Low magnesium level.
- Some drugs (cimetidine and propanalol).

Calcium	PTH	Interpretation
Normal	Normal	Calcium regulating system is normal.
Low	High	Gland working normal, check other reasons for hypocalcaemia.
Low	Normal/Low	Probably has hypoparathyroidism.
High	High	Gland producing excess PTH.
High	Low	PTH gland responding correctly, test non parathyroid cause for elevated calcium

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 56096

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897972 / 17007914	Report Date	: 20/May/2026 11:01AM
Sample Type	: EDTA Plasma	Report Status	: Final Report

IMMUNOLOGY

PARATHYROID PROFILE

Test Name	Result	Unit	Bio. Ref. Interval	Method

Note : Intact PTH has been demonstrated to be labile and is susceptible to fragmentation. This instability depends on both time and temperature.

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
2nd Floor, B-225, Okhla Phase I, Okhla
Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
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Reg No: 56096

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897974 / 17007914	Report Date	: 19/May/2026 12:51PM
Sample Type	: Urine	Report Status	: Final Report

CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Urine Routine & Microscopy				
Physical & Chemical Examination				
Colour	Pale Yellow		Pale Yellow	
Appearance	Clear		Clear	
Specific gravity	1.015		1.003 - 1.035	pKa change
pH	<=5.0		4.6 - 8.0	Double Indicator
Glucose	Negative		Negative	GOD-POD
Protein	Negative		Negative	Protein Error Principle
Ketones	Negative		Negative	Nitroprusside
Blood	Negative		Negative	Peroxidase
Bilirubin	Negative		Negative	Diazonium
Urobilinogen	Normal		Normal	Ehrlich
Leucocyte Esterase	Negative		Negative	Pyrrole
Nitrite	Negative		Negative	P-arsanilic acid
Microscopic Examination				
Pus cells	1-2	/hpf	0-5	Microscopy
Red Blood Cells	Nil	/hpf	0-2	Microscopy
Epithelial cells	1-2	/hpf	Few	Microscopy
Casts	Nil	/lpf	Nil	Microscopy
Crystals	Nil		Nil	Microscopy
Yeast	Nil		Nil	Microscopy
Bacteria	Nil		Nil	Microscopy

Comment:

•Note: Pre-test condition to be observed while submitting the sample-first void, mid stream urine, collected in a clean, dry, sterile container is recommended for routine urine analysis, avoid contamination with any discharge from vaginal, urethra, perineum, Avoid prolonged transit time & undue exposure to sunlight.
•During interpretation, points to be considered are Negative nitrite test does not exclude the urinary tract infections. Trace proteinuria can be seen with many physiological conditions like prolonged recumbency, exercise, high protein diet. False positive reactions for bile pigments, proteins, glucose and nitrites can be caused by peroxidase like activity by disinfectants, therapeutic dyes, ascorbic acid and certain drugs.• Urine microscopy is done in centrifuged urine specimens

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: JCMR 5830/18

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PO No :PO10002361144-150

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 62Y 4M 18D /Female	Referred By	: Dr.
Lab Visit ID	: RNC25709	Collection Date	: 19/May/2026 06:15AM
Barcode ID/Order ID	: D31897968 / 17007914	Report Date	: 19/May/2026 02:48PM
Sample Type	: STOOL	Report Status	: Final Report

CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
Stool Examination R/M				
Colour	Brownish		Yellow/Brownish	Physical Examination
Consistency	Semi Formed			Physical Examination
Reaction	Alkaline			
Visible blood	Absent		Not Detected	Physical Examination
Mucus	Absent		Not Detected	Physical Examination
Parasites	Not Seen		Not Detected	Physical Examination
Pus cells (Stool)	1-2	/hpf	0-5	Microscopy
Red blood cells	Nil	/hpf	Not Detected	Microscopy
Epithelial cells	Absent			
Cysts	Not Seen		Not Detected	Microscopy
Ova	Not Seen		Not Detected	Microscopy

Comment:

Result pertain to a portion of stool sample examined.
Contamination of stool with urine should be avoided.
In clinical suspicion of stool ova /parasite / worm segment, it is advised to submit at least 3 samples collected on alternate days (i.e. Day 1, Day 3 & Day 5) for optimal results.

***** End Of Report *****

NABL certificate and scope

This test has been performed at
TATA 1MG RANCHI
Shop No. 201 and 202, Bhagwati Complex, Plot No. 878, Second Floor, Area 8, Ward No. 30, Vill. Ranchi Harmu Road, Ranchi Jharkhand - 834002

Dr. Luna Sinha
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Consultant Pathologist
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