TATA 1mg | Labs®

PERSONAL HEALTH SMART REPORT

Prepared for

Kamla Sharma

Basic Info

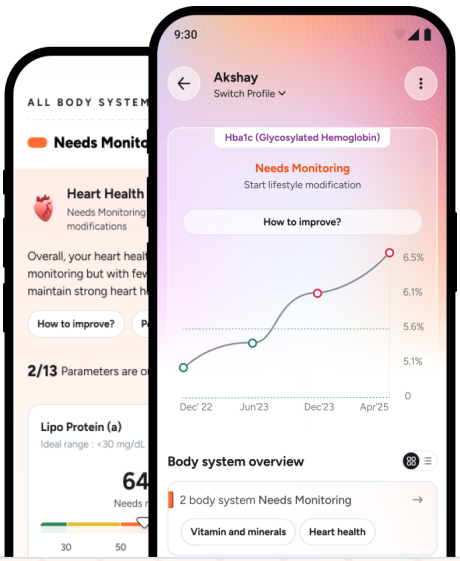
Female /61 Yrs

Sample collection date

15/11/2025

View detailed health insights, and trends on Tata 1mg app.

Click here



Doctor Summary For

Comprehensive Platinum Full Body Checkup with Smart Report

Note This is an electronically generated summary of the attached report. Please review it together with the full report for complete context, and seek guidance from a qualified doctor if needed. Reference ranges may differ by laboratory, methodology, or equipment; dates and historical results reflect the ranges valid when tests were performed.

Test Name	Result	Bio. Ref. Interval	Trends (For last three tests)		
Complete Blood Count	15 Nov 25		01 May 25	27 Oct 22	-
Hemoglobin	12.2 g/dL	12.0 - 15.0	12.2 (12.0 - 15.0)	-	-
RBC	4.01 10^6/cu.mm	3.8 - 4.8	**3.51** (3.8 - 4.8)	-	-
HCT	38.0 %	36 - 46	37.1 (36 - 46)	-	-
RDW-CV	**14.9** %	11.5 - 14	**17.0** (11.5 - 14)	-	-
Total Leucocyte Count	7.34 10^3/ÂµL	4 - 10	6.33 (4 - 10)	-	-
Neutrophils	52.5 %	40 - 80	51.7 (40 - 80)	-	-
Lymphocytes	38.9 %	20 - 40	34.1 (20 - 40)	-	-
Monocytes	4.9 %	2 - 10	9.2 (2 - 10)	-	-
Eosinophils	3.5 %	1 - 6	4.6 (1 - 6)	-	-
Basophils	0.2 %	0 - 2	0.4 (0 - 2)	-	-
Absolute Basophil Count	**0.01** 10^3/ÂµL	0.02 - 0.1	0.03 (0.02 - 0.1)	-	-
Platelet Count	227 10^3/ÂµL	150 - 410	189 (150 - 410)	-	-
Inflammatory markers	15 Nov 25		01 May 25	27 Oct 22	-
Erythrocyte Sedimentation Rate	20 mm/hr	0 - 20	**22** (0 - 20)	-	-
C-Reactive Protein (Quantitative)	**5.30** mg/L	0 - 3.3	<0.5 (0 - 3.3)	-	-

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Test Name	Result	Bio. Ref. Interval	Trends (For last three tests)		
Iron Studies	15 Nov 25		01 May 25	27 Oct 22	-
Iron Serum	**43** Âµg/dL	50 - 170	57 (50 - 170)	-	-
Total Iron Binding Capacity (TIBC)	269.1 Âµg/dL	250 - 460	279.4 (250 - 460)	-	-
Transferrin saturation	**15.98** %	16 - 50	20.40 (16 - 50)	-	-
Ferritin	40.70 ng/mL	10 - 291	45.00 (10 - 291)	-	-
Diabetes Profile	15 Nov 25		01 May 25	27 Oct 22	-
Glycosylated Hemoglobin (HbA1c)	**6.2** %	4 - 5.6	**6.1** (4 - 5.6)	-	-
Glucose - Fasting	**103** mg/dL	70 - 99	96 (70 - 99)	-	-
Microalbumin-Albumin	< 3 mg/L	0 - 29.99	< 5.0 (0 - 29.99)	-	-
Microalbumin-Albumin/Creatinine Ratio	**< 30** mg/g Creatinine	0 - 29.99	<30 (0 - 29.99)	-	-
Kidney Function Test	15 Nov 25		01 May 25	27 Oct 22	-
Creatinine	0.76 mg/dL	0.55 - 1.02	0.84 (0.55 - 1.02)	-	-
Uric Acid	**6.3** mg/dL	2.7 - 6.1	**6.5** (2.7 - 6.1)	-	-
Sodium	144 mEq/L	136 - 145	143 (136 - 145)	-	-
Potassium	4.48 mEq/L	3.5 - 5.1	3.84 (3.5 - 5.1)	-	-
Chloride	**110.0** mEq/L	98 - 107	**108.0** (98 - 107)	-	-

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Test Name	Result	Bio. Ref. Interval	Trends (For last three tests)		
Lipid Profile	15 Nov 25		01 May 25	27 Oct 22	-
Cholesterol - Total	118 mg/dL	<= 199.9	104 (<= 199.9)	-	-
Triglycerides	124 mg/dL	<= 149.9	144 (<= 149.9)	-	-
Cholesterol - HDL	**34** mg/dL	>= 49.9	**36** (>= 39.9)	-	-
Cholesterol - LDL	60 mg/dL	<= 99.9	39 (<= 99.9)	-	-
Non HDL Cholesterol	84 mg/dl	0 - 129.9	68 (<= 129.9)	-	-
Cardiac Profile	15 Nov 25		01 May 25	27 Oct 22	-
Homocysteine	**18.66** umol/L	3.7 - 13.9	**33.64** (3.7 - 13.9)	-	-
High sensitivity CRP	0.87 mg/L	0 - 3	0.72 (<= 3)	-	-
Lipoprotein (a)	**42.90** mg/dL	0 - 30	29.80 (0 - 30)	-	-
Apolipoprotein - A1	102.00 mg/dL	76 - 214	120.00 (76 - 214)	-	-
Apolipoprotein - B	58.00 mg/dL	46 - 142	50.00 (46 - 142)	-	-
Apolipoprotein B/A1 Ratio	**0.57** Ratio	0.6 - 0.9	0.42 (Ratio)	-	-
Liver Function Test	15 Nov 25		01 May 25	27 Oct 22	-
Bilirubin - Total	0.29 mg/dL	0.2 - 1.1	0.36 (0.2 - 1.1)	-	-
Bilirubin-Indirect	**0.18** mg/dL	0.2 - 0.8	0.22 (0.2 - 0.8)	-	-
Protein, Total	6.80 g/dL	5.7 - 8.2	7.20 (5.7 - 8.2)	-	-
Albumin	4.00 g/dL	3.2 - 4.8	4.30 (3.2 - 4.8)	-	-

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Test Name	Result	Bio. Ref. Interval	Trends (For last three tests)		
Liver Function Test	15 Nov 25		01 May 25	27 Oct 22	-
Aspartate Transaminase (SGOT)	30 U/L	0 - 33.9	29 (<= 34)	-	-
Alanine Transaminase (SGPT)	29 U/L	10 - 49	25 (10 - 49)	-	-
Alkaline Phosphatase	104 U/L	46 - 116	98 (46 - 116)	-	-
Gamma Glutamyltransferase (GGT)	9 U/L	0 - 37.9	12 (<= 37)	-	-
Pancreas Profile	15 Nov 25		01 May 25	27 Oct 22	-
Amylase	89 U/L	30 - 118	87 (30 - 118)	-	-
Lipase	**66.0** U/L	12 - 53	**62.0** (12 - 53)	-	-
Urine Routine & Microscopy	15 Nov 25		01 May 25	27 Oct 22	-
Specific gravity	1.015	1.003 - 1.035	1.015 (1.003 - 1.035)	-	-
pH	<=5.0	4.6 - 8	6.0 (4.6 - 8)	-	-
Glucose	Negative	Negative	Negative (Negative)	-	-
Protein	Negative	Negative	Negative (Negative)	-	-
Ketones	Negative	Negative	Negative (Negative)	-	-
Pus cells	1-2 /hpf	0 - 5	1-2 (0 - 5)	-	-
Red blood cell	Nil /hpf	0 - 2	Nil (0 - 2)	-	-
Casts	Nil /lpf	Nil	Nil (Nil)	-	-

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Test Name	Result	Bio. Ref. Interval	Trends (For last three tests)		
Urine Routine & Microscopy	15 Nov 25		01 May 25	27 Oct 22	-
Crystals	Nil	Nil	Nil (Nil)	-	-
Calcium and Bone Health	15 Nov 25		01 May 25	27 Oct 22	-
Calcium	**8.3** mg/dL	8.7 - 10.4	8.5 (8.3 - 10.6)	-	-
Vitamin D (25-OH)	40.2 ng/ml	30 - 100	**17.2** (20 - 100)	-	-
Phosphorus	4.60 mg/dl	2.4 - 5.1	4.80 (2.4 - 5.1)	-	-
Vitamin Profile	15 Nov 25		01 May 25	27 Oct 22	-
Vitamin B12	**170.0** pg/ml	211 - 911	**149.0** (211 - 911)	-	-
Vitamin B9	12.47 ng/ml	>= 5.38	6.15 (>= 5.39)	-	-
Thyroid Function Test	15 Nov 25		01 May 25	27 Oct 22	-
T3, Total	1.24 ng/mL	0.60 - 1.81	0.90 (0.60 - 1.81)	-	-
T4, Total	10.2 Âµg/dl	4.5 - 12.6	9.1 (4.5 - 12.6)	-	-
Thyroid Stimulating Hormone - Ultra Sensitive	**7.275** uIU/ml	0.55 - 4.78	4.368 (0.55 - 4.78)	-	-
Free T4	1.20 ng/dL	0.89 - 1.76	1.07 (0.89 - 1.76)	-	-
Free T3	2.67 pg/mL	2.3 - 4.2	2.75 (2.3 - 4.2)	-	-
Arthritis Screening	15 Nov 25		01 May 25	27 Oct 22	-
Rheumatoid Factor - Quantitative	< 3.5 IU/mL	0 - 13.9	<9.3 (0 - 14)	-	-

Doctor Summary For

Comprehensive Platinum Full Body Checkup with Smart Report

Test Name	Result	Bio. Ref. Interval	Trends (For last three tests)		
Allergy Panel	15 Nov 25		01 May 25	27 Oct 22	-
Immunoglobulin E (IgE) Total	**299** IU/mL	0 - 158	**257** (0 - 158)	-	-

PO No :PO10000481748-505

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920868 / 14852345	Report Date	: 15/Nov/2025 03:17PM
Sample Type	: EDTA	Report Status	: Final Report

HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	12.2	g/dL	12.0 - 15.0	Spectrophotometry (Cyanide-free)
RBC	4.01	10^6/cu.mm	3.8 - 4.8	Impedence
HCT	38.0	%	36 - 46	Calculated
MCV	94.9	fL	83 - 101	Calculated
MCH	30.4	pg	27 - 32	Calculated
MCHC	32.0	g/dL	31.5 - 34.5	Calculated
RDW-CV	**14.9**	%	11.5-14	Calculated
Total Leucocyte Count	7.34	10^3/µL	4 - 10	Impedance
Differential Leucocyte Count				
Neutrophils	52.5	%	40-80	DHSS/Microscopy
Lymphocytes	38.9	%	20-40	DHSS/Microscopy
Monocytes	4.9	%	2-10	DHSS/ Microscopy
Eosinophils	3.5	%	1-6	DHSS/Microscopy
Basophils	0.2	%	0-2	DHSS/ Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	3.85	10^3/µL	2 - 7	Calculated
Absolute Lymphocyte Count	2.86	10^3/µL	1-3	Calculated
Absolute Monocyte Count	0.36	10^3/µL	0.2 - 1	Calculated
Absolute Eosinophil Count	0.26	10^3/µL	0.02 - 0.5	Calculated
Absolute Basophil Count	**0.01**	10^3/µL	0.02-0.1	Calculated
Platelet Count	227	10^3/µL	150 - 410	Impedance/Microscopy
MPV	10.1	fL	6.5 - 12	Calculated
PDW	13.4	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.

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

Monika Bharti
Dr. Monika Bharti
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: 49359

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Sample Type	: EDTA	Report Status	: Final Report

HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Erythrocyte Sedimentation Rate				
Erythrocyte Sedimentation Rate	20	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

This test has been performed at
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Age/Gender	: 61/Female	Referred By	: Dr.
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Barcode ID/Order ID	: D25920868 / 14852345	Report Date	: 15/Nov/2025 03:17PM
Sample Type	: WHOLE BLOOD-EDTA	Report Status	: Final Report

HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
HbA1c (Glycosylated Hemoglobin)				
Glycosylated Hemoglobin (HbA1c)	**6.2**	%	4-5.6	HPLC (NGSP certified)
Estimated average glucose (eAG)	131.24	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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Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920869 / 14852345	Report Date	: 15/Nov/2025 03:17PM
Sample Type	: Fluoride Plasma F	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
FBS (Fasting Blood Sugar)				
Glucose - Fasting	**103**	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%

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Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920867 / 14852345	Report Date	: 15/Nov/2025 03:17PM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipid Profile				
Cholesterol - Total	118	mg/dL	Low (desirable): < 200 mg/dL Moderate (borderline) 200–239 mg/dL High: >/= 240 mg/dL	CHOD-POD
Triglycerides	124	mg/dL	Normal: <150, Borderline: 150 - 199, High:200-499, Very High>=500	GPO
Cholesterol - HDL	**34**	mg/dL	High risk <50mg/dL Low risk>=50mg/dL	Accelerator Selective Detergent
Cholesterol - LDL	60	mg/dL	Desirable: <100 Above desirable: 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : >=190	Calculated
Cholesterol- VLDL	25	mg/dL	<30	Calculated
Cholesterol : HDL Cholesterol	3.5	Ratio	Desirable : 3.0-4.0 High risk : >4	Calculated
LDL : HDL Cholesterol	1.78	Ratio	Desirable : 2.0-2.5 High risk : >3.0	Calculated
Non HDL Cholesterol	84	mg/dl	Desirable:< 130, Above Desirable:130 - 159, Borderline High:160 - 189, High:190 - 219, Very High: >= 220	Calculated

Comment:

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BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name **Result** **Unit** **Bio. Ref. Interval** **Method**

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

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BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

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

LIVER FUNCTION TEST

Liver Function Test

Test Name	Result	Unit	Bio. Ref. Interval	Method
Bilirubin-Total	0.29	mg/dL	0.2 – 1.1	Vanadate oxidation
Bilirubin-Direct	0.11	mg/dL	0.0-0.3	Vanadate oxidation
Bilirubin-Indirect	**0.18**	mg/dL	0.2-0.8	Calculated
Protein, Total	6.80	g/dL	5.7–8.2	Biuret
Albumin	4.00	g/dL	3.2-4.8	BCG Dye Binding
Globulin	2.8	g/dL	2.3 - 4.1	Calculated
A/G Ratio	1.43	Ratio	0.8 - 1.9	Calculated
SGOT (Aspartate Aminotransferase)	30	U/L	<34	Modified IFCC
SGPT (Alanine Transaminase)	29	U/L	10-49	Modified IFCC
SGOT/SGPT	1.03	Ratio		Calculated
Alkaline Phosphatase	104	U/L	46-116	IFCC Standardization
Gamma Glutamyltransferase (GGT)	9	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,

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Manika Bharti
Dr. Monika Bharti
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: 49359

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PO No :PO10000481748-505

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920867 / 14852345	Report Date	: 15/Nov/2025 03:17PM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

tissue damage, malabsorption, or increased renal excretion.

Kidney Function Test with eGFR (18 Years & Above)

Blood Urea Nitrogen	18	mg/dL	9.0-23	Urease with GLDH
Urea	37.45	mg/dL	19.26-49.22	Calculated
Creatinine	0.76	mg/dL	0.55-1.02	Alkaline picrate-kinetic
Uric Acid	**6.3**	mg/dL	2.7-6.1	Uricase/Peroxidase
Sodium	144	mEq/L	136-145	Indirect ISE
Potassium	4.48	mEq/L	3.5-5.1	Indirect ISE
Chloride	**110.0**	mEq/L	98-107	Indirect ISE
BUN/Creatinine Ratio	23.0	Ratio	12:1 - 20:1	Calculated
Glomerular Filtration Rate (estimated)	89	mL/min/1.73m2		Calculated

Calcium

Calcium	**8.3**	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	4.60	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)

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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.

Iron Studies, Comprehensive

Iron Serum	**43**	µg/dL	50-170	Ferrozine
Total Iron Binding Capacity (TIBC)	269.1	µg/dL	250-460	Calculated
Unsaturated Iron Binding Capacity	226	µg/dL	120-470	Ferene
Transferrin saturation	**15.98**	%	16-50	Calculated
Ferritin	40.70	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

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Consultant Pathologist
Reg. No: 49359

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binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

*Please note change in BRI of Ferritin.

Lipase

Lipase	**66.0**	U/L	12–53	Colorimetric rate

Comment:

Pancreas is the major and primary source of serum lipase, though lipase is also secreted by the gastric and intestinal mucosa. Lipase measurement in serum is used to diagnose acute pancreatitis.
After an attack of acute pancreatitis, serum Lipase activity increases within 4 to 8 hours,peaks at about 24 hours, and decreases over 8 to 14 days. Concentrations often remain elevated longer than those of Amylase.The increase in serum Lipase activity is not necessarily proportional to the severity of the attack.

Increased levels are seen in:

- Acute & Chronic Pancreatitis.
- Obstruction of Pancreatic duct.
- Non pancreatic conditions like renal disease,intestinal obstruction,acute cholecystitis,duodenal ulcer,alcoholism,diabetic ketoacidosis and following endoscopic retrograde cholangiopancreatography(ERCP).

Amylase

Amylase	89	U/L	30.0 - 118.0	Ethylidene Blocked-pNPG7

Comment:

- Amylase is a digestive enzyme mainly secreted by pancreas and salivary glands.
- An elevation of serum amylase beyond three times the upper limit of normal, combined with either clinical symptoms and/or imaging findings, may indicate acute pancreatitis. Serum amylase levels typically rise within 6 to 48 hours and usually return to baseline within 3 to 7 days. However, because of its short half-life, amylase levels may normalize as quickly as 24 hours after onset. Additionally, around 20% of patients with acute pancreatitis may have normal or near-normal amylase levels. Therefore, lipase, which is more specific to pancreatitis, should be measured alongside amylase to improve diagnostic accuracy.
- Elevated amylase levels can also be associated with conditions such as pancreatic duct obstruction, pancreatic carcinoma, or pancreatic pseudocysts. Additionally, increased amylase levels may occur in cholecystitis, renal disease, acute alcohol

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poisoning, following procedures like endoscopic retrograde cholangiopancreatography (ERCP) and even in non-pancreatic conditions like penetrating peptic ulcers, duodenal obstruction, mumps, ectopic pregnancy, and severe diabetic ketoacidosis.

- In asymptomatic individuals, elevated amylase levels may be attributed to macroamylasemia or idiopathic hyperamylasemia; amylase levels may fluctuate. Transient increases in amylase may also result from inflammation, alcohol consumption, or medications such as aspirin, diuretics, oral contraceptives, corticosteroids, indomethacin, and opiates.
- Low amylase levels are seen in chronic pancreatitis, congestive heart failure, 2nd & 3rd trimester of pregnancy, gastrointestinal cancer & bone fractures. Highly lipemic samples may show falsely low amylase levels.

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Monika Bharti
Dr. Monika Bharti
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: 49359

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Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipoprotein (a)				
Lipoprotein(a)	**42.90**	mg/dL	0 - 30	Immunoturbidimetric

Comment:

Note: Lipoprotein(a)[Lp(a)] is considered an important risk factor for Coronary Heart Disease (CHD).

* Lipoprotein (a) consists of an LDL particle that is covalently bound to an additional protein, apolipoprotein (a). Apo(a) has high-sequence homology with the coagulation factor plasminogen and, like LDL, Lp(a) contains apolipoprotein B100 . Thus, Lp(a) is both proatherogenic and prothrombotic. Lp(a) is an independent risk factor for CHD, Ischemic Stroke, and Aortic Valve Stenosis.
* Lp(a) is highly heterogeneous molecule; the degree of atherogenicity of the Lp(a) particle may depend on the molecular size of the Lp(a)-specific protein.
* Serum concentrations of Lp(a) are related to genetic factors, and are largely unaffected by diet, exercise and lipid -lowering pharmaceuticals. However, in a patient with additional modifiable CHD risk factors, more aggressive therapy to normalize these factors may be indicated if the Lp(a) value is also increased.

Usage:

Evaluation of increased risk for cardiovascular disease and events:
* In individuals at intermediate risk for cardiovascular disease
* In patients with early atherosclerosis
* In patients with strong family history of early CHD

NABL certificate and scope

MC - 5424

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

Dr. Dhananjay Singh
MBBS, MD(Pathology)
Consultant Pathologist
Reg No: 63325

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BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
High Sensitive CRP				
High sensitivity CRP	0.87	mg/L	Healthy Individuals: <= 3.0 Low Risk: < 1.0 Average Risk: 1.0 to 3.0 High Risk: > 3.0	Immunoturbidimetriy

Comment:

Note:

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)

Apolipoproteins A1 & B				
Apolipoprotein - A1	102.00	mg/dL	76-214	PEG immunturbidimetric

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Monika Bharti
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MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: 49359

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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
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BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Apolipoprotein - B	58.00	mg/dL	46- 142	PEG immunturbidimetric
Apolipoprotein B/A1 Ratio	**0.57**	Ratio	0.6-0.9	Calculated

Comment:

Apolipoprotein A1

- Apolipoproteins A1 (Apo A1) is the major apolipoprotein attached to HDL and is found in greater proportion than Apo A2 (3:1).
- It is inversely related to the risk of coronary artery disease (CAD).
- It may be a better predictor of atherogenic risk than HDL.

Apo A1 may be increased with	Apo A1 may be decreased with
Drugs (carbamazepine, estrogens, ethanol, statins,niacin, oral contraceptives, phenobarbital)	Chronic renal failure
Familial hyper alpha-lipoproteinemia	Coronary artery disease and peripheral vascular disease
Physical excercise	Drugs (androgens, beta blockers, diuretics and progestins)
Pregnancy	Familial hypo alpha-lipoproteinemia
Weight reduction	Smoking & Uncontrolled diabetes 2

Apolipoprotein B

- Apolipoprotein B (Apo B) is a major protein component of low density lipoprotien (LDL), Comprising >90% of the LDL. It is a more powerful independent predictor of coronary artery disease (CAD) than LDL cholesterol. It is useful in assessing the risk of CAD and to classify Hyperlipidemias.
- Apolipoprotein studies help in monitoring coronary bypass surgery patients with regard to risk and severity of restenosis.They are also useful in assessing risk of re-infarction in patients with Myocardial infarction .
- In patients with hyperapobetalipoproteinemia (HALB), a disorder associated with increased risk of developing CHD and with an estimated prevalence of 30% in patients with premature CAD, Apo B is increased disproportionately in LDL cholesterol. Apo B quantitation is used in distinguishing HALB from another common lipoprotein abnormality, Familial combined hyperlipidemia.

Apolipoprotein B:A1 Ratio

This test has been performed at
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Elevated ApoB/ApoA1 ratio confers increased risk of atherosclerotic cardiovascular disease independently of LDL and HDL cholesterol concentrations.

Apo B to A1 ratio	
Ratio	Remarks
0.35- 0.98	Desirable
>0.98	Increased CAD risk

C-Reactive Protein Quantitative

C-Reactive Protein (Quantitative)	**5.30**	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.

Rheumatoid Factor - Quantitative

Rheumatoid Factor - Quantitative	< 3.5	IU/mL	0-14	Turbidimetry

Comment:

- The detection of Rheumatoid factor (RF) is one of the criteria of the American Rheumatism Association (ARA) for the diagnosis of Rheumatoid Arthritis (RA).
- RF are heterogeneous group of auto antibodies directed against Fc- region of IgG molecules.
- They are useful in diagnosis of Rheumatoid Arthritis, but can also be found in other inflammatory diseases and in various non-rheumatic diseases.

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Reg. No: 49359

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- These occur in all the immunoglobulin classes, although the usual analytical methods are limited to the detection of Rheumatoid Factors of the IgM type.Healthy individuals >65 years of age may also show positive RF results.

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Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920870 / 14852345	Report Date	: 15/Nov/2025 03:17PM
Sample Type	: Urine	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Microalbumin Creatinine Ratio, Urine				
Microalbumin-Albumin	< 3	mg/L	<30	Turbidimetric
Urinary Creatinine	29.84	mg/dL	15-278	Kinetic Alkaline Picrate
Microalbumin-Albumin/Creatinine Ratio	**< 30**	mg/g Creatinine	<30	Calculated

Minimum detection limit of Microalbumin is 3.0 mg/L; this sample contains microalbumin less than 3.0 mg/L, hence, Microalbumin:Creatinine ratio could not be evaluated.

Comment:

Microalbumin/Albumin-to-Creatinine Ratio (UACR) Categories

ACR Category	UACR (mg/g creatinine)	Terms
A1	<30	Normal
A2	30 - 299	Microalbuminuria
A3	>=300	Clinical Albuminuria

Note: ACR categories: A1 - normal to mildly increased; A2 - moderately increased; A3 - severely increased.
(Source- American Diabetes Association (ADA):Standards of Care in Diabetes-2024)

- As per ADA, due to high biological variability (>20%) between measurements of urinary albumin excretion; two out of three specimens collected within a 3-to 6-month period should be abnormal before considering albuminuria (after excluding non-renal causes).
- Certain factors may raise UACR even without kidney damage - **physiological** like exercise within 24 hours, menstruation, pregnancy, benign postural proteinuria or **pathological** like infection (UTI), hematuria, fever, marked hyperglycemia, congestive heart failure, marked hypertension & poor metabolic control. A high albumin-to-creatinine ratio can be due to low urinary creatinine seen in females, low muscle mass, low protein intake or acute kidney injury.
- A random spot urine sample can be used, but due to high variability, it is recommended that abnormal UACR (>= 30 mg/g) should be confirmed with subsequent first morning midstream sample or 24 hr urine collection.
- Due to inherent day to day variability in albumin excretion, UACR is a better indicator than urine albumin alone. Microalbuminuria is defined as the small but abnormal increase in the excretion of urinary albumin (30-300 mg/g creatinine), but it is recommended to use the term albuminuria for ACR >= 30 mg/g creatinine.
- Persistent albuminuria present for a minimum of 3 months is one of the diagnostic markers of kidney damage and used for classification of chronic kidney disease (CKD).

Clinical Utility: Useful in early screening of diabetic nephropathy, as a risk marker for stroke & heart disease and also for classification and progression of CKD.

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Sample Type	: Urine	Report Status	: Final Report

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Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920867 / 14852345	Report Date	: 15/Nov/2025 04:24PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Immunoglobulin E (IgE) Total	**299**	IU/mL	0 - 158	CLIA

Comment:

- Immunoglobulin E (IgE) is the most important trigger molecule for allergic information.
- As IgE is a mediator of allergic response, quantitative measurement can provide useful information for differential diagnosis of atopic and non-atopic disease.
- The level of IgE is low during the first year of life, gradually increases with age and reaches adult level after 10 years.

Uses

- For Allergy testing.
- Evaluation of children and adults suspected of having allergic respiratory disease
- To confirm clinical expression of sensitivity to foods in patients with Anaphylactic sensitivity or with Asthma, Angioedema or Cutaneous disease.
- To confirm the presence of IgE antibodies to certain occupational allergens

Increased Levels:

Atopic/Non-atopic allergy, Hyper IgE syndrome, Parasitic infections, IgE Myeloma, Bronchopulmonary Aspergillosis, Immunodeficiency states & Autoimmune diseases, Hodgkin's disease,etc.

Decreased Levels:

Hereditary deficiencies, Acquired immunodeficiency, Ataxia Telangiectasia, Non IgE Myeloma

Note:

Normal levels of IgE does not eliminate the possibility of allergic diseases
No close correlation has been demonstrated between severity of allergic reaction and IgE levels.

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

Thyroid profile Total

T3, Total	1.24	ng/mL	0.60-1.81	CLIA
T4, Total	10.2	µg/dl	4.5-12.6	CLIA
Thyroid Stimulating Hormone -	**7.275**	uIU/ml	0.55-4.78	CLIA

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

Monika Bharti
Dr. Monika Bharti
MBBS, MD (Pathology)
Consultant Pathologist
Reg. No: 49359

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PO No :PO10000481748-505

Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920867 / 14852345	Report Date	: 15/Nov/2025 04:24PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Ultrasensitive				

Comment:

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

Pregnancy			
	TSH (µIU/mL) (as per American Thyroid Association)	Total T3 (ng/mL)	Total T4(µg/dL)
1st trimester	0.1-2.5	0.81-1.90	7.33-14.8
2nd trimester	0.2-3.0	1.00-2.60	7.93-16.1
3rd trimester	0.3-3.0	1.00-2.60	6.95-15.7

- 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.
- Total T3 & T4 concentrations are altered by physiological or pathological changes in thyroxine binding globulin (TBG) capacity .
- 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.
- Changes in thyroid status are typically associated with concordant changes in T3, T4 and TSH levels.
- Unexpectedly abnormal or discordant thyroid test values may be seen with some rare, but clinically significant conditions such as central hypothyroidism, TSH-secreting pituitary tumors, thyroid hormone resistance, or the presence of heterophilic antibodies (HAMA) or thyroid hormone autoantibodies.
- For diagnostic purposes, results should be used in conjunction with other data.

TSH	T3	T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism

This test has been performed at
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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920867 / 14852345	Report Date	: 15/Nov/2025 04:24PM
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Test Name	Result	Unit	Bio. Ref. Interval	Method

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Monika Bharti

Dr. Monika Bharti

MBBS, MD (Pathology)

Consultant Pathologist

Reg. No: 49359

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Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920867 / 14852345	Report Date	: 16/Nov/2025 10:47AM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Free T4	1.20	ng/dL	0.89-1.76	CLIA

Comment:

- Below mentioned are the guidelines for pregnancy related reference ranges for free T4.

Pregnancy	Reference Ranges(ng/dL)
1st trimester	0.7-2.0
2nd trimester	0.5-1.6
3rd trimester	0.5-1.6

- FT4 is the biologically active fraction of thyroxine in circulating blood.
- In patients with hyperthyroidism, the FT4 concentration increases, whereas in patients with hypothyroidism it generally decreases.
- Patients on hormone replacement therapy may have an elevation of FT4, although clinically they are euthyroid.
- The determination of free T4 has the advantage of being independent of changes in the concentrations and binding properties of the binding proteins.
- For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

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
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism

NABL certificate and scope

MC - 5424

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

Dr. Dhananjay Singh
MBBS, MD(Pathology)
Consultant Pathologist
Reg No: 63325

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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
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Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Free T3	2.67	pg/mL	2.3-4.2	CLIA

Comment:

- Below mentioned are the guidelines for pregnancy related reference ranges for free T3.

Pregnancy	Reference Ranges(pg/mL)
1st trimester	2.0-3.8
2nd trimester	2.0-3.8
3rd trimester	2.0-3.8

- Free T3 measurements support the differential diagnosis of thyroid disorders, are needed to distinguish different forms of hyperthyroidism, to identify patients with T3 thyrotoxicosis, monitoring of patients with hypothyroidism treated with Thyroxine and antithyroid agents.
- The determination of free T3 has the advantage of being independent of changes in the concentrations and binding properties of the binding proteins.
- For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

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
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism

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

Vitamin D (25-OH)

Vitamin D (25-OH)	40.2	ng/ml	Deficiency:< 20,	CLIA

This test has been performed at
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Monika Bharti
Dr. Monika Bharti
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Consultant Pathologist
Reg. No: 49359

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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
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Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
			Insufficiency:20-29, Sufficiency:30 - 100, Toxicity possible:> 100	

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.

Vitamin B12

Vitamin B12	**170.0**	pg/ml	211-911	CLIA

This test has been performed at
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Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
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IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

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.

Vitamin B9 (Folic Acid)

Vitamin B9 (Folic Acid)	12.47	ng/ml	0.35-3.37 Deficient 3.38-5.38 Indeterminate >5.38 Normal	CLIA

Comment:

Folate plays an important role in the synthesis of purine & pyrimidines in the body and is important for the maturation of erythrocytes. It is widely available from plants and to a lesser extent organ meats, but more than half the folate content of food is lost during cooking. Folate deficiency is commonly prevalent in alcoholic liver disease, pregnancy, and the elderly. It may result from poor intestinal absorption, nutrition deficiency, excessive demand as in pregnancy or in malignancy, and in response to certain drugs like Methotrexate & anticonvulsants. It is now routine practice to recommend dietary folate supplements from conception to the 12th week of pregnancy; such supplementation has been proven to reduce the incidence of neural tube defects.

Decreased Levels: Megaloblastic anemia, Infantile hyperthyroidism, Alcoholism, Malnutrition, Scurvy, Liver disease, B12 deficiency, dietary amino acid excess, adult Celiac disease, Tropical Sprue, Crohn's disease, Hemolytic anemias, Carcinomas, Myelofibrosis, vitamin B6 deficiency, pregnancy, Whipple's disease, extensive intestinal resection, and severe exfoliative dermatitis.

Note:
Certain drugs like Pyrimethamine, methotrexate, and trimethoprim are all folate antagonists i.e. they stop the action of the folic acid; phenytoin can decrease the intestinal absorption of folates, and ethanol both decreases absorption and increases excretion of folic acid.

To differentiate vitamin B12 & folate deficiency, measurement of Methylmalonic acid in urine & serum Homocysteine level is suggested.

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

This test has been performed at
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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
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Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Homocysteine				
Homocysteine	**18.66**	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.
*__CMIA__-Chemiluminescent Microparticle Immunoassay /__CLIA__-Chemiluminescent immunoassay.

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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920870 / 14852345	Report Date	: 15/Nov/2025 03:10PM
Sample Type	: Urine	Report Status	: Final Report

CLINICAL PATHOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

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

This test has been performed at
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Customer Name	: Ms.KAMLA SHARMA	Collected Via	: TATA 1MG RANCHI
Age/Gender	: 61/Female	Referred By	: Dr.
Lab Visit ID	: RNC8777	Collection Date	: 15/Nov/2025 06:02AM
Barcode ID/Order ID	: D25920870 / 14852345	Report Date	: 15/Nov/2025 03:10PM
Sample Type	: Urine	Report Status	: Final Report

CLINICAL PATHOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

*** End Of Report ***

Disclaimer:

1. The reported results based on laboratory investigation, are only for the purposes of diagnosis and should be clinically correlated and interpreted by the referring physician/ medical practitioner. For any queries relating to the reported results, you may write to our customer support team on care@1mg.com
2. It is presumed that the tests performed are, on the specimen / sample being to the patient named or identified and the verifications of particulars have been confirmed by the patient or his / her representative at the point of generation of said specimen.
3. The reported results are restricted to the given specimen only. Results may vary from lab to lab and from time to time for the same parameter for the same patient (within subject biological variation).
4. The patient's details along with their results in certain cases like notifiable diseases and as per local regulatory requirements will be communicated to the assigned regulatory bodies.
5. The patient samples can be used as part of internal quality control, test verification, data analysis purposes within the testing scope of the laboratory.
6. This report is not valid for medico legal purposes. It is performed to facilitate medical diagnosis only.
7. Pregnant women should seek guidance from a qualified obstetrician as test parameters may vary during pregnancy

This test has been performed at

TATA 1MG RANCHI

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Monika Bharti

Dr. Monika Bharti

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