

LABORATORY TEST REPORT










Name	: Mrs. RAJYA LAKSHMI		
Sample ID	: A1841682		
Age/Gender	: 66 Years/Female	Reg. No	: 0312503060006
Referred by	: Dr. SRIKANTH	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 06-Mar-2025 08:18 AM
Primary Sample	: Whole Blood	Received On	: 06-Mar-2025 12:56 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 06-Mar-2025 01:23 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report













HAEMATOLOGY

Test Name	Results	Units	Biological Reference Interval
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Complete Blood Picture(CBP)

 Haemoglobin (Hb) (Method: Cymeth Method)	12.6	g/dL	12-15
 Haematocrit (HCT) (Method: Calculated)	37.1	%	40-50
 RBC Count (Method: Cell Impedance)	4.51	10 ¹² /L	3.8-4.8
 MCV (Method: Calculated)	82	fl	81-101
 MCH (Method: Calculated)	27.8	pg	27-32
 MCHC (Method: Calculated)	33.9	g/dL	32.5-34.5
 RDW-CV (Method: Calculated)	15.2	%	11.6-14.0
 Platelet Count (PLT) (Method: Cell Impedance)	245	10 ⁹ /L	150-410
 Total WBC Count (Method: Impedance)	6.9	10 ⁹ /L	4.0-10.0

Differential Leucocyte Count (DC)

 Neutrophils (Method: Cell Impedance)	70	%	40-70
 Lymphocytes (Method: Cell Impedance)	25	%	20-40
 Monocytes (Method: Microscopy)	03	%	2-10
 Eosinophils (Method: Microscopy)	02	%	1-6
 Basophils (Method: Microscopy)	00	%	1-2
 Absolute Neutrophils Count (Method: Impedance)	4.83	10 ⁹ /L	2.0-7.0
 Absolute Lymphocyte Count (Method: Impedance)	1.73	10 ⁹ /L	1.0-3.0
 Absolute Monocyte Count (Method: Calculated)	0.21	10 ⁹ /L	0.2-1.0
 Absolute Eosinophils Count (Method: Calculated)	0.14	10 ⁹ /L	0.02-0.5
 Absolute Basophil ICount (Method: Calculated)	0.00	10 ⁹ /L	0.0-0.3

Morphology

(Method: PAPS Staining)

Anisocytosis with Normocytic normochromic



LABORATORY TEST REPORT

Name	: Mrs. RAJYA LAKSHMI		
Sample ID	: A1841679		
Age/Gender	: 66 Years/Female	Reg. No	: 0312503060006
Referred by	: Dr. SRIKANTH	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 06-Mar-2025 08:18 AM
Primary Sample	: Whole Blood	Received On	: 06-Mar-2025 01:00 PM
Sample Tested In	: Serum	Reported On	: 06-Mar-2025 03:01 PM
Client Address	: Kimtee colony , Gokul Nagar, Tarnaka	Report Status	: Final Report



CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Biological Reference Interval
Vitamin- B12 (cyanocobalamin) (Method: CLIA)	1580	pg/mL	200-911

Interpretation:

This test is most often done when other blood tests suggest a condition called megaloblastic anemia. Pernicious anemia is a form of megaloblastic anemia caused by poor vitamin B12 absorption. This can occur when the stomach makes less of the substance the body needs to properly absorb vitamin B12.






Causes of vitamin B12 deficiency include: Diseases that cause malabsorption

- Lack of intrinsic factor, a protein that helps the intestine absorb vitamin B12
- Above normal heat production (for example, with hyperthyroidism)

An increased vitamin B12 level is uncommon in:

- Liver disease (such as cirrhosis or hepatitis)
- Myeloproliferative disorders (for example, polycythemia vera and chronic myelogenous leukemia)
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Iron Profile-I

 Iron(Fe) (Method: Ferrozine)	57	µg/dL	50-170
 Total Iron Binding Capacity (TIBC) (Method: Ferrozine)	280	µg/dL	250-450
 Transferrin (Method: Calculated)	195.8	mg/dL	250-380
 Iron Saturation((% Transferrin Saturation) (Method: Calculated)	20.36	%	15-50
 Unsaturated Iron Binding Capacity (UIBC) (Method: Colorimetric)	223	ug/dL	110-370

Interpretation:

- Serum transferrin (and TIBC) high, serum iron low, saturation low. Usual causes of depleted iron stores include blood loss, inadequate dietary iron. RBCs in moderately severe iron deficiency are hypochromic and microcytic. Stainable marrow iron is absent. Serum ferritin decrease is the earliest indicator of iron deficiency if inflammation is absent.
- **Anemia of chronic disease:** Serum transferrin (and TIBC) low to normal, serum iron low, saturation low or normal. Transferrin decreases with many inflammatory diseases. With chronic disease there is a block in movement to and utilization of iron by marrow. This leads to low serum iron and decreased erythropoiesis. Examples include acute and chronic infections, malignancy and renal failure.
- **Sideroblastic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron normal to high, saturation high.
- **Hemolytic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron high, saturation high.
- **Hemochromatosis:** Serum transferrin (and TIBC) slightly low, serum iron high, saturation very high.
- **Protein depletion:** Serum transferrin (and TIBC) may be low, serum iron normal or low (if patient also is iron deficient). This may occur as a result of malnutrition, liver disease, renal disease.
- **Liver disease:** Serum transferrin variable; with acute viral hepatitis, high along with serum iron and ferritin. With chronic liver disease (eg, cirrhosis), transferrin may be low. Patients who have cirrhosis and portacaval shunting have saturated TIBC/transferrin as well as high ferritin.

*** End Of Report ***




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MD BIOCHEMISTRY

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