TATA 1mg | Labs®

PERSONAL HEALTH SMART REPORT

Prepared for

Fateh Singh

Basic Info

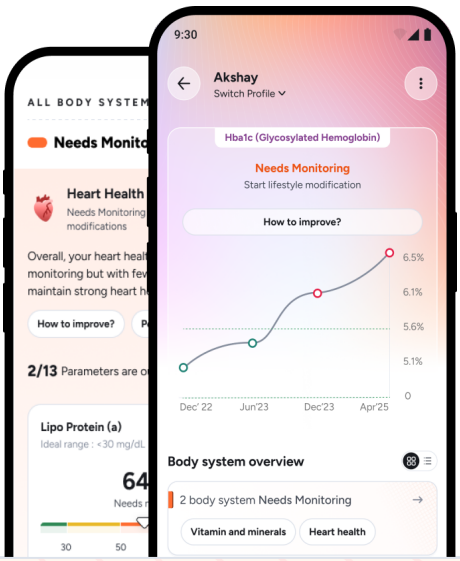
Male /8 Yrs

Sample collection date

14/06/2026

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

Click here



Doctor Summary

Comprehensive Gold Full Body Checkup With Smart Report

Note This is an electronically generated **summary of clinically significant parameters of the attached report.** It is advised to read this summary in conjunction with the attached report and to correlate it clinically. For the trends section, the out-of-range values are highlighted with respect to the bio-reference range of respective reports.

Test Name	Result	Bio. Ref. Interval
Complete Blood Count	14 Jun 26	
Hemoglobin	12.2 g/dL	11.5 - 15.5
RBC	4.81 mili/cu.mm	4.0 - 5.2
HCT	37.0 %	35 - 45
MCV	**76.9** fL	77 - 95
RDW-CV	**14.8** %	11.5 - 14
Total Leucocyte Count	7.29 10^3/µL	4.7 - 12.2
Neutrophils	38 %	37 - 70
Lymphocytes	39 %	22 - 55
Monocytes	8.9 %	2 - 10
Eosinophils	**13.5** %	1 - 8
Basophils	0.6 %	0 - 1
Absolute Eosinophil Count	**0.98** 10^3/µL	0.1 - 0.6
Platelet Count	349 10^3/µL	170 - 450
Inflammatory markers	14 Jun 26	
Erythrocyte Sedimentation Rate	1 mm/hr	0 - 20

Trends (For last three tests)

Book more tests with Tata 1mg to start viewing trends. Your health journey starts here!

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Comprehensive Gold Full Body Checkup With Smart Report

Test Name	Result	Bio. Ref. Interval
Inflammatory markers	14 Jun 26	
C-Reactive Protein (Quantitative)	< 1.0 mg/L	0 - 4.9
Iron Studies	14 Jun 26	
Iron Serum	47 µg/dL	16 - 128
Unsaturated Iron Binding Capacity	**288** µg/dL	69 - 240
Total Iron Binding Capacity (TIBC)	335.07 µg/dL	250 - 460
Transferrin Saturation	**14.03** %	20 - 50
Diabetes Profile	14 Jun 26	
Glucose - Fasting	82 mg/dL	70 - 99
Glycosylated Hemoglobin (HbA1c)	5.6 %	4 - 5.6
Microalbumin-Albumin	6.60 mg/L	0 - 29.99
Microalbumin-Albumin/Creatinine Ratio	8.37 mg/g creatinine	0 - 29.999
Kidney Health	14 Jun 26	
Creatinine	**0.50** mg/dL	0.52 - 0.69
Uric Acid	3.4 mg/dL	2.4 - 5.5
Sodium	140 mmol/L	138 - 145

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Test Name	Result	Bio. Ref. Interval
Kidney Health	14 Jun 26	
Potassium	**5.51** mmol/L	3.4 - 4.7
Chloride	**108.0** mmol/L	98 - 107
Lipid Profile	14 Jun 26	
Cholesterol - Total	147 mg/dL	<= 169.9
Triglycerides	61 mg/dL	<= 74.9
Cholesterol - HDL	52 mg/dL	>= 39.5
Cholesterol - LDL	83 mg/dl	<= 109.9
Non HDL Cholesterol	95 mg/dL	<= 119.9
Liver Health	14 Jun 26	
Bilirubin - Total	**0.19** mg/dL	0.3 - 1.2
Protein, Total	6.99 g/dL	6.0 - 8.0
Albumin	4.63 g/dL	3.8 - 5.4
Aspartate Transaminase (SGOT)	23 U/L	18 - 36
Alanine Transaminase (SGPT)	10 U/L	9 - 25
Alkaline Phosphatase	227 U/L	153 - 367

Trends (For last three tests)

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Test Name	Result	Bio. Ref. Interval
Liver Health	14 Jun 26	
Gamma Glutamyltransferase (GGT)	15 U/L	10 - 26
Urine Routine & Microscopy	14 Jun 26	
Specific gravity	1.016	1.000 - 1.030
pH	5.5	5 - 8
Glucose	Negative	Negative
Protein	Negative	Negative
Ketones	Negative	Negative
Pus cells	0.20 /hpf	0 - 5
Red blood cell	0.00 /hpf	0 - 2
Calcium and Bone Health	14 Jun 26	
Vitamin D (25-OH)	27.0 ng/mL	20 - 100
Calcium	**9.3** mg/dL	9.3 - 10.5
Vitamins & Minerals	14 Jun 26	
Vitamin B12	351.0 pg/mL	187 - 833
Vitamin B9	**3.00** ng/mL	3.1 - 20.5

Trends (For last three tests)

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Test Name	Result	Bio. Ref. Interval
Thyroid Health	14 Jun 26	
T3, Total	**1.09** ng/mL	1.13 - 1.89
T4, Total	7.1 µg/dL	6.2 - 10.3
Thyroid Stimulating Hormone - Ultra Sensitive	2.438 µIU/mL	0.7 - 4.2
Arthritis Screening	14 Jun 26	
Rheumatoid Factor - Quantitative	< 20.0 IU/mL	0 - 29.9

Trends (For last three tests)

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TATA 1mg | Labs
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www.1mg.com/labs care@1mg.com CIN: U74140DL2015PTC279229
ISO 9001:2015

PO No :PO10002723642-178

Customer Name	: Mr.FATEH SINGH	Collected Via	: TATA 1MG BANGALORE
Age/Gender	: 8Y 5M 13D /Male	Referred By	: Dr.
Lab Visit ID	: MGB1816683	Collection Date	: 14/Jun/2026 06:35AM
Barcode ID/Order ID	: D32703656 / 17368893	Report Date	: 14/Jun/2026 12:24PM
Sample Type	: WHOLE BLOOD-EDTA	Report Status	: Final Report

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	12.2	g/dL	11.5 - 15.5	Spectrophotometry (Cyanide-free)
RBC	4.81	mili/cu.mm	4.0 - 5.2	Impedence
HCT	37.0	%	35 - 45	Calculated
MCV	**76.9**	fL	77 - 95	Calculated
MCH	25.4	pg	25 - 33	Calculated
MCHC	33.0	g/dL	31 - 37	Calculated
RDW-CV	**14.8**	%	11.5-14	Calculated
Total Leucocyte Count	7.29	10^3/µL	4.7 - 12.2	Impedance
Differential Leucocyte Count				
Neutrophils	38	%	37-70	DHSS/Microscopy
Lymphocytes	39	%	22-55	DHSS/Microscopy
Monocytes	8.9	%	2-10	DHSS/Microscopy
Eosinophils	**13.5**	%	1-8	DHSS/Microscopy
Basophils	0.6	%	0-1	Impedance/Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	2.77	10^3/µL	1.8 - 7.6	Calculated
Absolute Lymphocyte Count	2.84	10^3/µL	1.7 - 4.5	Calculated
Absolute Monocyte Count	0.65	10^3/µL	0.2 - 0.9	Calculated
Absolute Eosinophil Count	**0.98**	10^3/µL	0.1 - 0.6	Calculated
Absolute Basophil Count	0.04	10^3/µL	0 - 0.1	Calculated
Platelet Count	349	10^3/µL	170 - 450	Impedance/Microscopy
MPV	8.9	fL	6.5 - 12	Calculated
PDW	14.1	fL	9-17	Calculated

Absolute Eosinophilia.
Advice:- Serum IgE Level.

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

NABL certificate and scope

This test has been performed at
TATA 1MG BANGALORE
No 607, Ground, 1st & 2nd Floor, 80 Feet Road, 6th Block, Koramangala, Bengaluru, 560095

Dr. Vinisha Nahata
MBBS, DCP (Pathology)
Consultant Pathologist
Reg No: 108310

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HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Calculated parameters are either derived from Impedence measure, RBC pulse measurement, RBC/platelet histograms or formula derived.				
Erythrocyte Sedimentation Rate				
Erythrocyte Sedimentation Rate	1	mm/hr	0-20	Modified Westergren at 18C

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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Age/Gender	: 8Y 5M 13D /Male	Referred By	: Dr.
Lab Visit ID	: MGB1816683	Collection Date	: 14/Jun/2026 06:35AM
Barcode ID/Order ID	: D32703656 / 17368893	Report Date	: 14/Jun/2026 11:02AM
Sample Type	: WHOLE BLOOD-EDTA	Report Status	: Final Report

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
HbA1c (Glycosylated Hemoglobin)				
Glycosylated Hemoglobin (HbA1c)	5.6	%	4-5.6	HPLC (NGSP certified)
Estimated average glucose (eAG)	114.02	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	: 8Y 5M 13D /Male	Referred By	: Dr.
Lab Visit ID	: MGB1816683	Collection Date	: 14/Jun/2026 06:35AM
Barcode ID/Order ID	: D32703657 / 17368893	Report Date	: 14/Jun/2026 11:46AM
Sample Type	: Fluoride Plasma F	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
FBS (Fasting Blood Sugar)				
Glucose - Fasting	82	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

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	: 8Y 5M 13D /Male	Referred By	: Dr.
Lab Visit ID	: MGB1816683	Collection Date	: 14/Jun/2026 06:35AM
Barcode ID/Order ID	: D32703655 / 17368893	Report Date	: 14/Jun/2026 04:26PM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipid Profile				
Cholesterol - Total	147	mg/dL	Desirable <170 Borderline high 170–199 High >=200	Enzymatic
Triglycerides	61	mg/dL	Normal: <75, Borderline: 75 - 99, High:>=100	Glycerol Phosphate Oxidase
Cholesterol - HDL	52	mg/dL	Low HDL: <40 mg/dL Borderline Low: 40-45 mg/dL Acceptable: >45 mg/dL	Accelerator Selective Detergent
Cholesterol - LDL	83	mg/dl	Acceptable: <110 mg/dL Borderline High: 110-129 mg/dL High: > or =130 mg/dL	Calculated
Cholesterol- VLDL	12	mg/dl	<15	Calculated
Cholesterol : HDL Cholesterol	2.8	Ratio	Desirable : 3.5-4.5 High Risk : >5	Calculated
LDL : HDL Cholesterol	1.59	Ratio	Desirable : 2.5-3.0 High risk : >3.5	Calculated
Non HDL Cholesterol	95	mg/dL	Acceptable: <120 mg/dL Borderline High: 120-144 mg/dL High: >=145 mg/dL	Calculated

Comment:

●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

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BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

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

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

LIVER FUNCTION TEST

Liver Function Test

Bilirubin-Total	**0.19**	mg/dL	0.3-1.2	Diazonium Salt
Bilirubin-Direct	< 0.10	mg/dL	0.05-0.20	Diazo

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Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Bilirubin-Indirect	-	mg/dL	0.2-0.8	Calculated
Protein, Total	6.99	g/dL	6.0-8.0	Biuret
Albumin	4.63	g/dL	3.8-5.4	Bromocresol Green
Globulin	2.4	g/dL	2.1 - 3.2	Calculated
A/G Ratio	1.96	Ratio	1.27 - 1.99	Calculated
SGOT (Aspartate Aminotransferase)	23	U/L	18-36	NADH w/o P-5'-P
SGPT (Alanine Transaminase)	10	U/L	9-25	NADH w/o P-5'-P
SGOT/SGPT	2.30	Ratio		Calculated
Alkaline Phosphatase	227	U/L	153-367	Para-Nitrophenyl Phosphate
Gamma Glutamyltransferase (GGT)	15	U/L	10-26	L-gamma-glutamyl-3-Carboxy-4-Nitroanilide

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.

*Please note the change in BRI.
*Please note test values may vary depending on the assay method used.

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BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Kidney Function Test.				
Blood Urea Nitrogen	10	mg/dL	7.0-16.8	Urease
Urea	20.37	mg/dL	14.9 - 35.9	Calculated
Creatinine	**0.50**	mg/dL	0.52-0.69	Kinetic Alkaline Picrate
Uric Acid	3.4	mg/dL	2.4-5.5	Uricase
Sodium	140	mmol/L	138-145	INDIRECT ISE
Potassium	**5.51**	mmol/L	3.4-4.7	INDIRECT ISE
Chloride	**108.0**	mmol/L	98-107	INDIRECT ISE
BUN/Creatinine Ratio	19.0	Ratio	12:1 - 20:1	Calculated

Note: Mildly elevated potassium levels without symptoms may be retested with a fresh sample if needed. Causes can include kidney issues, dehydration, certain medications (e.g., ACE inhibitors, potassium-sparing diuretics), high-potassium foods (e.g., bananas, spinach, avocados), tissue damage, or blood collection errors. Persistent high levels should be discussed with your physician to explore potential underlying conditions or medication effects.

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.

Calcium

NABL certificate and scope

This test has been performed at
TATA 1MG BANGALORE
No 607, Ground, 1st & 2nd Floor, 80 Feet Road, 6th Block, Koramangala, Bengaluru, 560095

Dr. Vinisha Nahata
MBBS, DCP (Pathology)
Consultant Pathologist
Reg No: 108310

Scan for digital copy

PO No :PO10002723642-178

Customer Name	: Mr.FATEH SINGH	Collected Via	: TATA 1MG BANGALORE
Age/Gender	: 8Y 5M 13D /Male	Referred By	: Dr.
Lab Visit ID	: MGB1816683	Collection Date	: 14/Jun/2026 06:35AM
Barcode ID/Order ID	: D32703655 / 17368893	Report Date	: 14/Jun/2026 04:26PM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Calcium	**9.3**	mg/dL	9.3 - 10.5	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

Iron Studies, Basic

Iron Serum	47	µg/dL	16 -128	Ferene
Unsaturated Iron Binding Capacity	**288**	µg/dL	69 - 240	Ferrizone
Total Iron Binding Capacity (TIBC)	335.07	µg/dL	250-460	Calculated
Transferrin Saturation	**14.03**	%	20 - 50	Calculated

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

NABL certificate and scope

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Barcode ID/Order ID	: D32703655 / 17368893	Report Date	: 14/Jun/2026 04:26PM
Sample Type	: Serum	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
C-Reactive Protein Quantitative				
C-Reactive Protein (Quantitative)	< 1.0	mg/L	<5.0	Turbidimetry

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	< 20.0	IU/mL	<30 Negative 30-50 Weak Positive >50 Positive	Immunoturbidimetric

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.
- 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.

NABL certificate and scope

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Lab Visit ID	: MGB1816683	Collection Date	: 14/Jun/2026 06:35AM
Barcode ID/Order ID	: D32703658 / 17368893	Report Date	: 14/Jun/2026 11:57AM
Sample Type	: Urine	Report Status	: Final Report

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Microalbumin Creatinine Ratio, Urine				
Microalbumin-Albumin	6.60	mg/L	<30	Immunoturbidimetry
Urinary Creatinine	78.90	mg/dL	24-392	Kinetic Alkaline Picrate
Microalbumin-Albumin/Creatinine Ratio	8.37	mg/g creatinine	<30	Calculated

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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Barcode ID/Order ID	: D32703655 / 17368893	Report Date	: 14/Jun/2026 12:31PM
Sample Type	: Serum	Report Status	: Final Report

IMMUNOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Thyroid profile Total				
T3, Total	**1.09**	ng/mL	1.13-1.89	CMIA
T4, Total	7.1	µg/dL	6.2-10.3	CMIA
Thyroid Stimulating Hormone - Ultrasensitive	2.438	µIU/mL	0.7-4.2	CMIA

Adviced to do Free T3 and Free T4

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.

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IMMUNOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

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

Vitamin D (25-OH)

Vitamin D (25-OH)	27.0	ng/mL	Deficiency:< 15, Insufficiency:15-<20, Sufficiency:20 - 100, Toxicity possible:> 100	CMIA

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

NABL certificate and scope

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IMMUNOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

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).

Vitamin B12

Vitamin B12	351.0	pg/mL	187-833	CMIA

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.

Vitamin B9 (Folic Acid)

Vitamin B9 (Folic Acid)	**3.00**	ng/mL	3.1-20.5	CMIA

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.

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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.

NABL certificate and scope

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Sample Type	: Urine	Report Status	: Final Report

CLINICAL PATHOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Urine Routine & Microscopy				
Urine Routine	Automated			
Physical & Chemical Examination				
Colour	Pale yellow		Pale Yellow	Optical array
Appearance	Clear		Clear	Optical array
Specific gravity	1.016		1.000–1.030	Refractometry
pH	5.5		5.0 - 8.0	Double Indicator
Glucose	Negative		Negative	Glucose-oxidase
Protein	Negative		Negative	Tetra-bromphenol blue
Ketones	Negative		Negative	Sodium Nitroprusside
Blood	Negative		Negative	Tetramethyl benzidine
Bilirubin	Negative		Negative	Diazonium salt
Urobilinogen	Normal		Normal	Diazonium salt
Leucocyte Esterase	Negative		Negative	Carboxylic acid ester
Nitrite	Negative		Negative	Griess reaction
Ascorbic acid	Negative		Negative	Indophenol
Microscopic Examination				
Pus cells	0.20	/hpf	0.0-5.0	
Red Blood Cells	0.00	/hpf	0.0-2.0	
Epithelial cells	0.10	/hpf	0.0-5.0	
Yeast	0.00	/hpf	0.0-1.0	
Bacteria	Nil	/hpf	0.0-80.0	
Hyaline casts	0.00	/hpf	0.0-5.0	
RBC casts	0.00	/hpf	0.0-0.99	
WBC casts	0.00	/hpf	0.0-0.99	
Hyaline-granular casts	0.00	/hpf	0.0-0.99	
Fatty casts	0.00	/hpf	0.0-0.99	
Granular casts	0.00	/hpf	0.0-0.99	
Waxy casts	0.00	/hpf	0.0-0.99	
Microorganism casts	0.00	/hpf	0.0-0.99	

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CLINICAL PATHOLOGY

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Calcium oxalate monohydrate crystals	0.00	/hpf	0.0-0.99	
Calcium oxalate dihydrate crystals	0.30	/hpf	0.0-0.99	
Triple phosphate crystals	0.00	/hpf	0.0-0.99	
Uric acid crystals	0.00	/hpf	0.0-0.99	
Calcium phosphate	0.00	/hpf	0.0-0.99	
Cystine crystals	0.00	/hpf	0.0-0.99	
Leucine crystals	0.00	/hpf	0.0-0.99	
Tyrosine crystals	0.00	/hpf	0.0-0.99	
Amorphous Material	0.00	/hpf	0.0-0.99	

Comment:

- Urine microscopy is done in centrifuged urine specimens.
- Results should be interpreted in conjunction with clinical findings and other laboratory investigations.
- For optimum results, the sample should be a first-void, mid-stream urine collected in a clean, dry, and sterile container. Contamination from vagina, urethra, perineum may affect results.
- Presence of red blood cells may be influenced by menstruation.
- Certain medications, dehydration, or supplements may impact results.
- Microscopy findings are semi-quantitative and do not confirm infection; urine culture may be required.
- Trace proteinuria may be observed in various physiological conditions such as prolonged recumbency, strenuous exercise, or a high-protein diet.
- Interference: False-positive results for bile pigments, protein, glucose, and nitrites may occur due to disinfectants, peroxide-based cleaning agents, therapeutic dyes, vitamin C, or certain medications.
- Ascorbic acid (Vitamin C): May interfere with glucose, nitrite, bilirubin, and blood results; repeat testing is recommended after at least 10 hours or next day after stopping vitamin C.
- Blood: Small amounts of blood may not change urine colour and are detectable only by tests; false positives may occur due to infection or contamination. Occasionally strip tests may show higher value than microscopy due to lysed RBC.
- Leukocyte esterase: Results may be influenced by drugs, coloured compounds, high glucose or protein, and urine concentration; false positives can occur due to vaginal contamination or preservatives. Occasionally strip values may exceed microscopy due to lysed white blood cells or pus cells.

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

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Test Name	Result	Unit	Bio. Ref. Interval	Method

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

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Consultant Pathologist
Reg No: 108310

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