



First & Only Infection NGS Diagnostic Centre In Jammu, Kashmir & Ladakh

MEEM PATH LABS AND DIAGNOSTIC CENTRE

Advanced Histopathology - Cytopathology - Molecular Diagnostics - Hematology - Immunology - Biochemistry
Quality Assured Diagnostic Service, Internal & External Q.C

Patient ID 10261005039
Patient Name Ms. AMAIRAH IQBAL
Gender / Age Female/ 1 Mon
Refd. By Dr. Prof Kaiser Ahmad

Registered On 04/08/2026 19:23:43
Released On 04/08/2026 20:58:29
Contact No 6006247676



Report

HAEMATOLOGY

Investigation	Value	Unit	Biological Ref. Range
CBC (Complete Blood Count)			
Haemoglobin (Hb) Method: Photometric	12.2	g/dL	12.5 - 20.5
RBC Count Method: Electrical Impedance	3.72	millions/cu.mm	3.60 - 6.20
Mean Corpuscular Volume (MCV) Method: Electrical Impedance	94.9	fL	86.0 - 124.0
Hematocrit (HCT/PCV) Method: Electrical Impedance	35.3	%	31.0 - 71.0
Mean Corpuscular Hemoglobin (MCH) Method: Electrical Impedance	32.8	pg	31.0 - 37.0
Mean Corpuscular Hb Concentration (MCHC) Method: Electrical Impedance	34.6	g/dL	28.0 - 38.0
Red Cell Distribution Width (RDW-SD) Method: Automated Cell Counter	49.6	%	39.0 - 46.0
Red Cell Distribution Width (RDW-CV) Method: Automated Cell Counter	13.1	%	11.5 - 16.0
Total Leukocyte Count (TLC) Method: DC Detection	8.4	/cumm	6.0 - 22.0
Differential Leukocyte Count (DLC)			
Neutrophils Method: VCS	18.1	%	15 - 35
Lymphocytes Method: VCS	72.8	%	41 - 71
Eosinophils Method: VCS	4.8	%	0 - 3
Monocytes Method: VCS	4	%	0 - 7





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Basophils Method: VCS	0.3	%	0 - 1
Absolute Neutrophil Count Method: Electrical Impedance, Microscopy	1.52	10 ⁹ /L	2.0 - 7.0
Absolute Lymphocyte Count Method: Electrical Impedance, Microscopy	6.12	10 ⁹ /L	0.8 - 4.0
Absolute Monocyte Count Method: Electric Impedance, VCS/ Microscopy Calculated	0.34	Cells/cu mm	0.12 - 1.2
Absolute Eosinophil Count Method: Electrical Impedance, VCS/ Microscopy	0.4	10 ⁹ /L	0.02 - 0.5
Absolute Basophil Count Method: Electric Impedance, VCS/ Microscopy Calculated	0.0	10 ⁹ /L	0.0 - 0.1
Platelet Count Method: Electrical Impedance	287	Lac/cum	150 - 450
Mean Platelet Volume (MPV)	10.9	fL	7.5 - 11.2
Plateletcrit (PCT)	0.313	%	0.220 - 0.360
Platelet Distribution Width (PDW)	13.4	fL	9.0 - 17.0
PLCR	31.3	%	11.0 - 45.0
PLCC	90.0	%	30.0 - 90.0

Complete Blood Count (CBC) involves analyzing key blood cell components—red blood cells (RBCs), white blood cells (WBCs), and platelets—against normal reference ranges to identify potential health issues like anemia, infections, or clotting disorders. Key indicators include RBC and hemoglobin levels, WBC count and differential, and platelet count and Mean Platelet Volume (MPV). A doctor interprets these results in the context of symptoms, other tests, and individual factors to provide a diagnosis and treatment plan.

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Mudasir Manzoor
Lab Technologist

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Report

BIOCHEMISTRY

Investigation	Value	Unit	Biological Ref. Range
Liver Function Test (LFT)			
Protein Total Method: Biuret method	5.35	g/dL	6.4 - 8.3
Albumin Method: Bromocresol Green	4.1	g/dL	3.7 - 5.3
Globulin Method: Calculated	1.25	g/dL	2.3 - 3.5
A:G (Albumin:Globulin) Ratio Method: Calculated	3.28		1.2 - 2.0
SGOT/AST (Aspartate Amino-transferase) Method: NADH (without Pyridoxal-5'-phosphate)	57.14	U/L	0.0 - 40.0
SGPT/ALT (Alanine Amino-transferase) Method: NADH(without Pyridoxal - 5'-phosphate)	56.08	U/L	0.0 - 46.0
ALP (Alkaline Phosphatase) Method: IFCC/PNPP	228.38	U/l	<500.0
Bilirubin,Total Method: VANADATE OXIDATION METHODS	2.26	mg/dL	1.00 - 10.00
Bilirubin, Direct Method: Diazo Reaction	1.00	mg/dL	0.00 - 0.40
Bilirubin, Indirect Method: Calculated	1.26	mg/dL	0.10 - 1.00
GGTP (Gamma Glutamyl-Transferase) Method: L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrat	56.73	U/L	0.0 - 50.0

Liver function test interpretation involves analyzing blood levels of enzymes (ALT, AST, ALP, GGT), proteins (albumin, total protein), bilirubin, to identify patterns of liver damage. The pattern—hepatocellular (high ALT/AST), cholestatic (high ALP/GGT), or mixed—and the specific degree of elevation, alongside factors like albumin help pinpoint the cause and severity of liver injury or disease.





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Report

Creatine Kinase (CPK)
Method: NAC (N-acetyl-L-cysteine)

117.00

U/L

26.00 - 174.00

Skeletal muscle, myocardium, and brain are rich in the enzyme and it is released by tissue damage.

Clinical utility :- diagnosis and monitoring of myopathies, myocardial infarction and cerebral vascular disease

Increased in - Myocardial infarction (MI), myocarditis, muscle trauma, rhabdomyolysis, muscular dystrophy, polymyositis, severe muscular exertion, malignant hyperthermia, hypothyroidism, cerebral infarction, surgery, Reye syndrome, tetanus, generalized convulsions, alcoholism, IM injections, DC counter shock, Drugs: clofibrate, HMG-CoA reductase inhibitors.

* During an MI, serum CK level rises rapidly (within 3–5 hours); reaches a maximum after 12 – 14 hrs and returns to normal range after 3-4 days post-MI.

* Total CK is not specific enough for use in diagnosis of MI, but a normal total CK has a high negative predictive value.

* A more specific test is needed for diagnosis of MI or acute coronary syndrome (eg, CK-MB, Troponin T and Troponin I).



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Report

IMMUNOASSAY

Investigation	Value	Unit	Biological Ref. Range
PTH (Parathyroid Hormone) Intact Method: CLIA	53.90	pg/mL	15.00 - 65.00

Notes:

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

High PTH levels may be caused by:

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

Low PTH levels may be caused by:

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

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





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Report

FT4 (Free Thyroxine)
Method: CMIA

2.600

ng/dL

0.900 - 1.750



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TSH (Thyroid Stimulating Hormone) 0.033 uIU/ml 0.540 - 5.300
Method: CLIA

Interpretation:

TSH-us	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

Reference Range Age related		Reference Range Pregnancy	
Age	TSH-us	Pregnancy	TSH- us
0-1 day /(Cord Blood)	1.000 - 17.400	1st Timester	0.300 - 4.500
2day - 4days	1.000 - 39.000	2st Timester	0.500 - 4.600
2wks - 20wks	1.700 - 9.100	3st Timester	0.800 - 5.200
5mths - 24mths	0.800 - 8.200		
2yrs - 7yrs	0.700 - 5.700		
8yrs - 21yrs	0.700 - 5.700		
Adults (>21 yrs)	0.350 -4.940		

TSH Levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am. Nadir concentrations are observed during the afternoon. Diurnal variation in TSH levels is approx 50% +/-, hence time of the day can influence the measured serum concentration.



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Vitamin D, 25-Hydroxy
Method: CLIA

37.9

ng/mL

<20 : Deficient
20-30 : Insufficient
30-100 : Sufficient
>100 : Upper Safety Limit

Clinical utility:

- assessment of Vitamin D deficiency
- determination of adequacy of vitamin supplement (if on vitamin D replacement therapy)
- before drug treatment for osteoporosis
- when abnormal phosphorus, calcium or PTH levels are detected
- assessment of bone disease or bone weakness

Low levels seen in

- inadequate exposure to sunlight
- inadequate dietary intake, malabsorption, drugs like phenyto in Vitamin D deficiency may increase the risk of some cancers, immune diseases, and cardiovascular disease.

High levels are seen in excess supplementation from Vitamin pills or other nutritional supplements.

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

* For monitoring of therapy it is advisable to test parameters by same assay method.
The values with different methods cannot be used interchangeably due to difference in test procedures and reagent specificity.

*** End of Report ***

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