INSTITUTE OF LIVER & BILIARY SCIENCES

(An Autonomous Society under Government of NCT of Delhi)
D-1, Vasant Kunj, New Delhi, India
Phone No: 011-46300000 **Ext:** 17055 & 17056, 011-26706700– 02
Liver help line - 1-800-11-5354
Fax No: 46300010, **Email:** info@ilbs.in, **Website:** http://www.ilbs.in

LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: Who6037114	**SAMPLE TYPE**	: Whole Blood
SAMPLE COLLECTION DATE	: 25/01/2026 00:45	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 01:45
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 02:04
FINALISED BY	: Mr. Praveen Garg		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 00:43	**Print Date**	: 25/01/2026 02:03

HAEMATOLOGY

Parameter	Result	Flag	Units	Reference Range	Methodology
CBC (Fully Automatic Haematology Cell Counter)**					
HAEMOGLOBIN(PHOTOMETRIC METHOD)	**11.7**	L	gm/dl	13-17	Photometric Method
PCV / HAEMATOCRIT (CALCULATED)	**32.5**	L	%	40-50	Calculated
TOTAL LEUCOCYTE COUNT TLC (IMPEDANCE METHOD)	4.51		10~9/L	4-11	Impedance Method
PLATELET COUNT (IMPEDANCE METHOD)	**134**	LL	10~9/L	150-450	Impedance Method
DIFFERENTIAL LEUKOCYTE COUNT(FLOWCYTOMETRY METHOD)					
NEUTROPHILS	**87.3**	HH	%	40-75	
LYMPHOCYTES	**11.1**	LL	%	37-79	
MONOCYTES	**0.80**	L	%	2-10	
EOSINOPHILS	**0.8**	L	%	1-6	

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.CHHAGAN BIHARI
PROFESSOR

Result Entered By : Mr. Praveen Garg

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LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: Ser6037095	**SAMPLE TYPE**	: Serum
SAMPLE COLLECTION DATE	: 25/01/2026 00:45	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 04:47
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 08:07
FINALISED BY	: Mr. Ravindra		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 00:36	**Print Date**	: 25/01/2026 08:07

BIOCHEMISTRY

Parameter	Result	Flag	Units	Reference Range	Methodology
Liver Function Test / Profile**					
BILIRUBIN TOTAL{DPD}	**15.45**	HH	mg/dl	0.2-1.1	
BILIRUBIN DIRECT{DPD}	**8.5**	H	mg/dl	0-0.2	
BILIRUBIN INDIRECT (CALCULATED)	**6.95**	HH	mg/dl	0.2-0.8	Calculated
AST/SGOT {IFCCWITHOUT P5P}	**688**	HH	IU/L	5-40	
ALT /SGPT (IFCCWITHOUT P5P)	**1226**	HH	IU/L	0-30	
ALKALINE PHOSPHATASE{IFCC AMP BUFFER}	**205**	HH	IU/L	56-167	
GGT {IFCC}	**79**	H	IU/L	0-55	
TOTAL PROTEIN{BIURET}	**5.84**	L	g/dL	6.4-8.3	
ALBUMIN {BCP BROMOCRESOL GREEN}	**2.77**	L	g/dL	3.5-5.2	
GLOBULIN (CALCULATED)	3.07		gm/dl	2-3.5	
A\G RATIO (CALCULATED)	**0.91**	L		1.5-2.5	

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.Sherin Thomas
CONSULTANT- GR-III

Result Entered By : Mr. Ravindra

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D-1, Vasant Kunj, New Delhi, India
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Liver help line -1-800-11-5354
Fax No: 46300010, **Email:** info@ilbs.in, **Website:** http://www.ilbs.in

LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: WB 6037302	**SAMPLE TYPE**	: WB PLASMA
SAMPLE COLLECTION DATE	: 25/01/2026 09:42	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 10:22
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 12:45
FINALISED BY	: Dr. Sherin Thomas		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 09:40	**Print Date**	: 25/01/2026 12:45

BIOCHEMISTRY

Parameter	Result	Flag	Units	Reference Range
AMMONIA-PLASMA				
AMMONIA(ENZYMATIC)	**259.1**	HH	µg/dl	31-123

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.Sherin Thomas
CONSULTANT- GR-III

Result Entered By : Dr. Sherin Thomas

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LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: WB 6037096	**SAMPLE TYPE**	: WB PLASMA
SAMPLE COLLECTION DATE	: 25/01/2026 00:45	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 04:29
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 08:07
FINALISED BY	: Mr. Ravindra		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 00:36	**Print Date**	: 25/01/2026 08:07

BIOCHEMISTRY

Parameter	Result	Flag	Units	Reference Range
AMMONIA-PLASMA				
AMMONIA(ENZYMATIC)	**278.9**	HH	µg/dl	31-123

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.Sherin Thomas
CONSULTANT- GR-III

Result Entered By : Mr. Ravindra

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LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: PLA6037283		
SAMPLE COLLECTION DATE	: 25/01/2026 07:34	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 08:00
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 08:18
FINALISED BY	: Mr. Praveen Garg		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 00:36	**Print Date**	: 25/01/2026 08:18

COAGULATION

Parameter	Result	Units	Reference Range	Methodology
PT / PT-INR **				
PROTHROMBIN TIME(PT)	39.5	seconds	No reference range	Photo Optical Clot Detection
MEAN NORMAL PROTHROMBIN TIME(MNPT)	12.0	seconds	No reference range	
INR	3.49		No reference range	

INTERPRETATION

Note:
1. INR is the parameter of choice in monitoring adequacy of oral anticoagulant therapy. Appropriate therapeutic range varies with disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder/bleeding complications.
3. Result should be clinically correlated.
4. Test conducted on citrated plasma

Recommended therapeutic range for oral anticoagulant therapy
INR 2.0- 3.0 :
·Treatment of venous thrombosis & pulmonary embolism
· Prophylaxis of venous thrombosis(high risk surgery)
· Prevention of systemic embolism in tissue heart valves,AMI, · Bileaflet mechanical valve in aortic position
INR 2.5- 3.5 :
· Mechanical prosthetic valve
· Systemic recurrent emboli

Comments:Prothrombin time measures the extrinsic coagulation pathway which consists of activated factor VII (VIIa), tissue factor and proteins of control pathway (Factor X,V,II & Fibrinogen).This assay is used to control long term oral anticoagulant therapy, evaluation of liver function & to evaluate coagulation disorders specially factors involved in the extrinsic pathway like factors V,VII,X,Prothrombin & fibrinogen

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.CHHAGAN BIHARI
PROFESSOR

Result Entered By : Dr. CHHAGAN BIHARI

INSTITUTE OF LIVER & BILIARY SCIENCES
(An Autonomous Society under Government of NCT of Delhi)
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LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: PLA6037303		
SAMPLE COLLECTION DATE	: 25/01/2026 09:42	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 10:23
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 12:55
FINALISED BY	: MS. Sakshi Rawat		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 09:40	**Print Date**	: 25/01/2026 12:55

COAGULATION

Parameter	Result	Units	Reference Range	Methodology
PT / PT-INR **				
PROTHROMBIN TIME(PT)	64.7	seconds	No reference range	Photo Optical Clot Detection
MEAN NORMAL PROTHROMBIN TIME(MNPT)	12.0	seconds	No reference range	
INR	5.87		No reference range	

INTERPRETATION

Note:
1. INR is the parameter of choice in monitoring adequacy of oral anticoagulant therapy. Appropriate therapeutic range varies with disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder/bleeding complications.
3. Result should be clinically correlated.
4. Test conducted on citrated plasma

Recommended therapeutic range for oral anticoagulant therapy
INR 2.0- 3.0 :
·Treatment of venous thrombosis & pulmonary embolism
· Prophylaxis of venous thrombosis(high risk surgery)
· Prevention of systemic embolism in tissue heart valves,AMI, · Bileaflet mechanical valve in aortic position
INR 2.5- 3.5 :
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--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.CHHAGAN BIHARI
PROFESSOR

Result Entered By : Dr. CHHAGAN BIHARI

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LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: PLA6037303		
SAMPLE COLLECTION DATE	: 25/01/2026 09:42	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 10:23
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 13:13
FINALISED BY	: MS. Sakshi Rawat		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 09:40	**Print Date**	: 25/01/2026 13:13

COAGULATION

Parameter	Result	Units	Reference Range	Methodology
PT / PT-INR **				
PROTHROMBIN TIME(PT)	64.7	seconds	No reference range	Photo Optical Clot Detection
MEAN NORMAL PROTHROMBIN TIME(MNPT)	12.0	seconds	No reference range	
INR	5.87		No reference range	

INTERPRETATION

Note:
1. INR is the parameter of choice in monitoring adequacy of oral anticoagulant therapy. Appropriate therapeutic range varies with disease and treatment intensity.
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·Treatment of venous thrombosis & pulmonary embolism
· Prophylaxis of venous thrombosis(high risk surgery)
· Prevention of systemic embolism in tissue heart valves,AMI, · Bileaflet mechanical valve in aortic position
INR 2.5- 3.5 :
· Mechanical prosthetic valve
· Systemic recurrent emboli

Comments:Prothrombin time measures the extrinsic coagulation pathway which consists of activated factor VII (VIIa), tissue factor and proteins of control pathway (Factor X,V,II & Fibrinogen).This assay is used to control long term oral anticoagulant therapy, evaluation of liver function & to evaluate coagulation disorders specially factors involved in the extrinsic pathway like factors V,VII,X,Prothrombin & fibrinogen

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.CHHAGAN BIHARI
PROFESSOR

Result Entered By : Dr. CHHAGAN BIHARI

Disclaimer: "This is an amended report, Please ignore any previous results."

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 06:45PM
Barcode No	**: D1022012**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF HAEMATOLOGY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT(CBC)23				
R.B.C	5.12	Millions/cumm	4.5-5.5	Impedance variation
Haemoglobin	14.2	g/dl	13-17	Spectrophotometry
Packed Cell Volume	44.10	%	40.0-50.0	Analogical Integration
MCV	86.13	fL	80-100	
MCH	27.73	pg	27.0-32.0	Calculated
MCHC	32.2	g/dL	27.0-48.0	Calculated
RDW-CV	**14.7**	%	11.5-14.0	Calculated
Platelet Count	171	x1000/uL	150-450	Impedance Variation
Total WBC Count	4800	/cumm	4000-10000	Impedance Variation
TNC	4.80			
MPV	9.60	%	9.1-11.9	Calculated
PCT	**0.16**	%	0.18-0.39	Calculated
PDW	**17.50**	%	9.0-15.0	Calculated
Differential Leucocyte Count				
Neutrophil	62	%	40.0-80.0	flow cytometry/manual
Lymphocyte	28	%	20.0-40.0	flow cytometry/manual
Monocytes	08	%	2-10	flow cytometry/manual
Eosinophils	02	%	01-06	Flow cytometry/manual
Basophils	00	%	0-2	Flow cytometry/manual
Absolute Neutrophils	2.98	1000/uL	2.00-7.00	
Absolute Lymphocytes	1.34	1000/µL	1.00-3.00	
Absolute Monocytes	0.38	1000/µL	0.20-1.00	
Absolute Eosinophils	0.10	1000/µL	0.02-0.50	
Neutrophil-Lymphocyte Ratio	2.21			Calculated
Lymphocyte-Monocyte Ratio	4			Calculated
Platelet-Lymphocyte Ratio	6			Calculated

This report has been validated by:

DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

DR. SMRITHI KRISHNA C
M.B.B.S , M.D. (PATH)
CONSULTANT PATHOLOGIST
REGD NO. 83525

DR. SONAM
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 4268

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 06:47PM
Barcode No	**: D1022012**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF HAEMATOLOGY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
Erythrocyte Sedimentation Rate (ESR)	16	mm/h	0-20	Westergren

This report has been validated by:

DR. NEERU AGARWAL
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SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

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REGD NO. 83525

DR. SONAM
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SR. CONSULTANT PATHOLOGIST
REGD. NO. 4268

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:00PM
Barcode No	**: D1022014**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
PROTHROMBIN TIME & INR				
Sample Type : SODIUM CITRATE				
Patient Value (PT)	**39.50**	Sec	10.0 - 15.0	Triggered Coagulation & Clot Detection
Control Value (MN P.T)	11.50	Sec		Triggered Coagulation & Clot Detection
ISI	1.04			
International Normalised Ratio (INR)	**3.61**	Sec	1.00-1.30	Triggered Coagulation & Clot Detection

INTERPRETATION

1. PROLONGED PT

a.) Administration of oral anticoagulant drugs(Vitamin K antagonists)
b.) Liver disease , particularly obstructive.
c.) Vitamin K deficiency.
d.) Disseminated intravascular coagulation.
e.) Rarely, a previously undiagnosed factor VII,X,V or prothrombin deficiency defect.

2. SHORTENED PT

a) Shortening of P.T may occur due to inhibiton of coumarin action (Barbiturates, Rifampicin, estryamine,Antithistaminics,Vitamin K,isoeofulvin,Colchicine & many others) or missed/inadequate dosage of anticoagulants.
b) Acute inflammatory conditions may shorten P.T by several seconds due to increase in fibinogen content of plasma.
c) Intake of food/drinks within one hour (before or after) of oral anticoagulant drug ingestion, affects P.T results greatly,due to interference with drug absorption.

USES OF PT

1.TO MONITOR PATIENT WHO ARE ON ORAL ANTICOAGULANT THERAPY

a.) Any patient who takes oral anicoagulants requires frequent monitoring of Prothrombin time.Despite the most careful managment;frequent fluctuations in P.T can occur. Various drugs & metabolic changes which alter liver microsomal metabolism of coumarins or compete for albumin binding sites, can increase or decrease the biologic potency of a given anticoagulant dose.Prolongation of P.T may occur due to potentiation of coumarin action (Metronidazole, Clotrimoxazole,Phenylbutazone, Oxyphenbutazone,Indomethacin, Mefenamic acid, Aspirin,Heparin, Clofibrate, Corticosteroids, Quinidine,Oral contraceptives,Erythromycin,Ethanol,Tetracycline,Cloramphenicol, Phenytoin.
b.) Pregnancy may alter (shorten or prolong) prothrombin time greatly, thus necessitating readjustment of oral anticoagulant dosage.
2.TO ASSESS LIVER FUNCTION:-Liver is the site of synthesis of various coagulation factors.
3. To screen for hereditary deficiency of factors VII,X,V prothrombin,and fibrinogen.

This report has been validated by:

DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

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M.B.B.S , M.D. (PATH)
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REGD NO. 83525

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M.B.B.S , M.D. (PATH)
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REGD. NO. 4268

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:48PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE FASTING				
Sample Type : Sod.Fluoride - F				
Glucose Fasting	**119.7**	mg/dl	70.0 - 110.0	GOD-POD

Interpretation (In accordance with the American diabetes association guidelines):

· A fasting plasma glucose level below 110 mg/dL is considered normal.

· A fasting plasma glucose level between 100-126 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients.

· A fasting plasma glucose level of above 126 mg/dL is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dL on both the occasions is confirmatory of a diabetic state.

This report has been validated by:

DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:48PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
EGFR (ESTIMATED GLOMERULAR FILTRATION RATE)				
Creatinine	0.70	mg/dL	0.70-1.40	Jaffe Kinetic
Blood Urea Nitrogen (BUN)	7.1	mg/dL	6-20	spectrophotometry
Albumin (Serum)	3.59	g/dL	3.5-5.5	Bromo Cresol Green (BCG)
EGFR By MDRD	150.13	mL/min/1.73 m2		Spectrophotometric - Calculated

COMMENT-The Kidney Disease Improving Global Outcomes (KDIGO) guideline defines CKD by the presence of glomerular filtration rate (GFR) <60 mL/min/1.73m2 for >3 months and/or evidence of kidney damage (eg, structural abnormalities, histologic abnormalities, albuminuria, urinary sediment abnormalities, renal tubular disorders, and/or history of kidney transplantation) for >3months.2 Thus, monitoring should include tests for GFR, albuminuria, and urine sediment.

CLINICAL USE-

• Detect chronic kidney disease (CKD) in adults.

• Monitor CKD therapy and/or progression in adults.

Interpretation of eGFR Values	
eGFR (mL/min/1.73m^2)	**Interpretation**
90	Normal
60-89	Mild decrease
45-59	Mild to moderate decrease
30-44	Moderate to severe decrease
15-29	Severe decrease
<15	Kidney failure

This report has been validated by:

DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:11PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE BASIC				
Sample Type : SERUM				
Total Cholesterol	97.2	mg/dL	Desirable - 200, Borderline high - 200-239, High - ≥ 240	CHO-POD
Triglyceride	124.2	mg/dL	0.0-150 :Normal 151-199:Border Line >=200 :High 200.0-499.0 High ~> 500 Very High	GPO-POD
HDL Cholesterol	**20.2**	mg/dL	40-60	Direct (PVS/PEGME precipitation & Trinder reaction)
Non HDL Cholesterol	77.00	mg/dL	< 130 mg/dL	Calculated
VLDL Cholesterol	24.8	mg/dL	2.00-30.00	Calculated
LDL Cholesterol	52.16	mg/dL	0-130 :Normal~131-155:Borderline~>=160 :High	Direct (PVS/PEGME precipitation & Trinder reaction)
Cholesterol/HDL Ratio	**4.81**	Ratio	<4.00	Calculated
LDL / HDL Cholestrol Ratio	2.58	Ratio	<3.50	Calculated
HDL/LDL Cholesterol Ratio	0.39	Ratio	<3.50	Calculated

Cholesterol Level	**mg/dL**	
Desirable	200	
Borderline High	200 - 239	
High	≥ 240	
Risk Modifiers As per ASCVD		
PARAMETRS	**mg/dL**	
HDL	<40 - low	
	>60 - high	
LDL	<100 optimal	
TRIGLYCERIDE LEVELS	< 150 for fasting	
	< 175 for Non fasting	
Treatments Goal as per LAI 2023		
ASCVD RISK CATEGORY	**TREATMENT GOAL**	
	LDL-C in mg/dL Primary Target	**NonHDL-C in mg/dL CO-Primary Target**
LOW	<100	**<130**
MODERATE	<100	**<130**
HIGH	<70	**<100**
VERY HIGH	<50	**<80**
EXTREME (A)	<50 or <30	**<80 or <60**

This report has been validated by:

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Phd. BIOCHEMISTRY
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Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:11PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
EXTREME (B)	<30		**<60**	

This report has been validated by:

Pawan Kumar
DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

Neeru
DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:17PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
IRON PROFILE BASIC				
Iron, Serum	155.9	ug/dL	59-158	Colorimetric
Total Iron Binding Capacity-(TIBC)	360.9	ug/dL	250-400	Spectro-photometry
UIBC-SERUM	205.00	ug/dL	110-370	Direct Determination with Ferrozinc
Transferrin Saturation	43.20	%	16-50	Calculated

Total iron-binding capacity

The test measures the extent to which iron-binding sites in the serum can be saturated. Because the iron-binding sites in the serum are almost entirely dependent on circulating transferrin, this is really an indirect measurement of the amount of transferrin in the blood.

Taken together with serum iron and percent transferrin saturation clinicians usually perform this test when they are concerned about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, liver function must be considered when performing this test. It can also be an indirect test of liver function, but is rarely used for this purpose

Transferrin Saturation

1g of transferrin can carry 1.43g of iron. Normally, iron saturation of transferrin (transferrin saturation) is between 10% and 50%. Because of its short half-life, transferrin values decrease more quickly in protein malnutrition states and should be taken into consideration while evaluating iron-deficiency states

This report has been validated by:

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Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

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M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
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LAB HEAD
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Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:48PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
Kidney Function Test EXTENDED				
Urea	**15.2**	mg/dL	18.0-45.0	Urease UV
Creatinine	0.70	mg/dL	0.70-1.40	Jaffe Kinetic
Calcium	**8.0**	mg/dL	8.6-10.2	NM-BAPTA
Uric Acid	4.96	mg/dl	4.40-7.60	Spectro-photometry
Phosphorus	**2.38**	mg/dL	2.50-5.00	Ammonium molybdate UV
Sodium (NA+)	136.20	mmol/L	135.0-145.0	Ion Selective Electrode
Potassium (K+)	5.20	mmol/L	3.50-5.50	Ion Selective Electrode
Chloride	101.10	mmol/L	98.0-109.0	Ion Selective Electrode
Blood Urea Nitrogen (BUN)	7.1	mg/dL	6-20	spectrophotometry
Bun / Creatinine Ratio	10.14	Ratio	0.0-23.0	Calculated
Urea / Creatinine Ratio	21.71	Ratio	20-35	Calculated

Interpretation:- Kidney blood tests, or Kidney function tests, are used to detect and diagnose disease of the Kidney.

The higher the blood levels of urea and creatinine, the less well the kidneys are working.
The level of creatinine is usually used as a marker as to the severity of kidney failure. (Creatinine in itself is not harmful, but a high level indicates that the kidneys are not working properly. So, many other waste products will not be cleared out of the bloodstream.) You normally need treatment with dialysis if the level of creatinine goes higher than a certain value.
Dehydration can also be a come for increases in urea level.
Before and after starting treatment with certain medicines. Some medicines occasionally cause kidney damage (Nephrotoxic Drug) as a side-effect. Therefore, kidney function is often checked before and after starting treatment with certain medicines.

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M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
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M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

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Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 07:36PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF IMMUNOASSAY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE				
Sample Type : SERUM				
Triiodothyronine Total (T3)	**2.05**	ng/mL	0.70-2.04	Chemiluminescence Immunoassay (CLIA)
Thyroxine Total (T4)	**12.28**	ug/dL	4.6-10.5	Chemiluminescence Immunoassay (CLIA)
TSH (4th Generation)	**0.246**	uIU/mL	0.40-4.20	Chemiluminescence Immunoassay (CLIA)

PREGNANCY	REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association.)
1st Trimester	0.10-2.50 uIU/mL
2nd Trimester	0.20-3.00 uIU/mL
3rd Trimester	0.30-3.00 uIU/mL

INTERPRETATION-

1. Primary hyperthyroidism is accompanied by elevated serum T3 & T4 values along with depressed TSH level.
2 .Primary hypothyroidism is accompanied by depressed serum T3 and T4 values & elevated serum TSH levels.
3. Normal T4 levels accompanied by high T3 levels and low TSH are seen in patients with T3 thyrotoxicosis.
4. Normal or low T3 & high T4 levels indicate T4 thyrotoxicosis (problem is conversion of T4 to T3)
5. Normal T3 & T4 along with low TSH indicate mild / subclinical HYPERTHYROIDISM .
6. Normal T3 & low T4 along with high TSH is seen in HYPOTHYROIDISM .
7. Normal T3 & T4 levels with high TSH indicate Mild / Subclinical HYPOTHYROIDISM .
8. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propanolol.
9. Although elevated TSH levels are nearly always indicative of primary hypothroidism . rarely they can result from TSH secreting pituitary tumours (seconday hyperthyroidism)

TSH IS DONE BY ULTRASENSITIVE 4th GENERATION CHEMIFLEX ASSAY

COMMENTS:

Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Note:

TSH levels may fluctuate based on few factors such as pregnancy, illness and age. Also, time of sample collection, technologies used to analyze the test, usage of certain drugs. Diet may have impact on TSH levels. TSH may show around 50% variation even when done at different times of day due to its association with circadian rhythm.

This report has been validated by:

DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:39PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF SEROLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
Hepatitis C Antibody	0.17	AU/mL	0-1	CLIA

INTRODUCTION:

Hepatitis C Virus was identified in 1989 as the main aetiological agent of non-A, non-B hepatitis (NANBH) accounting for greater than 90% of posttransfusion hepatitis cases. HCV is a spherical virus of about 30-60 nm in diameter with single positive stranded RNA and is related to the family flaviviridae. It is considered to be the major cause of acute chronic hepatitis, liver cirrhosis and hepatocellular carcinoma throughout the world. Antibodies to HCV can be detected throughout virtually the total infection period. Therefore, the use of highly sensitive antibody assays is the primary approach in serodiagnosis of HCV infection. The diagnosis of hepatitis C can be easily made by finding elevated serum ALT levels and presence of antiHCV in serum/plasma.

COMMENTS:

1.This is an Antibody detection test and results might depend on immune response of the individual.
2.Patients with auto-immune liver diseases may show false reactive results.
3. HCV Antibodies might take 2 weeks to 5 months after acquiring HCV Infection.

NOTE:

This antibody may never become detectable in 5–10% of patients with acute hepatitis C, and levels of anti-HCV may rarely become undetectable after recovery. In patients with chronic hepatitis C, anti-HCV is detectable in >95% of cases.

This report has been validated by:

DR. SWATI JAIN
M.B.B.S , M.D. (MICRO)
CONSULTANT MICROBIOLOGIST
DMC NO. 61188

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

QR CODE

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 21/Jan/2026 08:39PM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF SEROLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
Hepatitis B Surface Antigen (HBsAg)	0.02	Index	0 - 0.05	CLIA

Comment:
This assay detects the first serological marker of Hepatitis B as early as 4-16 weeks after exposure. It persists during acute illness and disappears 12-20 weeks after onset of symptoms. The titers rise rapidly during the period of viral replication and is frequently associated with infectivity. Persistence of HBsAg for more than 6 months indicates development of carrier state or chronic liver disease. The enzyme immunoassay method for the detection of Hepatitis B surface antigen is a highly sensitive screening test and can therefore yield false positive results. The proportion of false reactives will depend on the sensitivity and specificity of the test kit. Hence it is recommended that a positive result of HBsAg must be be confirmed using a different enzyme immunoassay kit or by using a confirmatory assay based on neutralisation with human anti hepatitis B surface antibody.Based upon clinical history it may become necessary to test for presence of other markers of hepatitis B virus infection.
NOTE: It is a screening test result may be confirmed by another methods if indicated .To be correlated clinically.

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

This report has been validated by:

DR. SWATI JAIN
M.B.B.S , M.D. (MICRO)
CONSULTANT MICROBIOLOGIST
DMC NO. 61188

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

QR CODE

Baunthiyal
Path Labs & Imaging Centre Pvt. Ltd.

MC-6296

BO90127 240126

		LAB ID	: BO90127	**Sample Collection**	: 24/01/2026 11:48 AM
Name	: MR. SHUBHAM	**Age/Sex**	: 22 Yrs. / M	**Report Released**	: 24/01/2026 12:46 PM
Ref. By.	: SELF	**UH ID**	: B26222358	**Printed**	: 24/01/2026 12:53 PM
Sent By	: BPL-STAFF				

LIVER PROFILE (LFT), SERUM

Test		Result	Unit	Biological Ref. Range
BILIRUBIN	:	17.49	mg/dl	0 - 2.0 mg/dl
(Dichlorophenyldiazonium Tetrafluoroborate(DPD)				
Bilirubin (Direct)	:	9.23	mg/dl	0-0.2 mg/dl
Method :- Dichlorophenyldiazonium Tetrafluoroborate(DPD)				
Bilirubin (Indirect)	:	8.26	mg/dl	0.3 - 0.9 mg/dl
Method: Calculated				
S. G. O.T	:	958.35	U/L	0-50 U/L
Method :- IFCC (with/without pyridoxal phosphate activation)				
S. G. P. T	:	1635.4	U/L	10 - 40 U/L
Method :- IFCC (with/without pyridoxal phosphate activation)				
Total Proteins	:	7.0	g/dl	6.6 - 8.3 g/dl
Method: Biuret				
Serum Albumin	:	3.46	g/dl	3.5 - 5.2 g/dl
Method: BCG				
Globulin	:	3.54	g/dl	2.8 - 4.0 g/dl
Method: Calculated				
A/G Ratio	:	0.98		1.0-2.5
Method: Calculated				
Alkaline Phosphatase	:	218	U/L	53 - 128 U/L
Method : - p-nitrophenyl phosphate (PNPP)				
Remark	:	Result rechecked		

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Elevated levels results from increased bilirubin production (eg hemolysis and ineffective erythropoiesis); decreased bilirubin excretion (eg; obstruction and hepatitis); and abnormal bilirubin metabolism (eg; hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in viral hepatitis; drug reactions, alcoholic liver disease conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome.

AST levels increase in viral hepatitis, blockage of the bile duct ,cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. Ast levels may also increase after a heart attck or strenuous activity. ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyriodism, Leukemia, Lymphoma, paget`s disease, Rickets, Sarcoidosis etc.

Elevated serum GGT activity can be found in diseases of the liver, Biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-including drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic - Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver.Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

NOT VALID FOR MEDICO LEGAL PURPOSES

Dr. (Maj) Yashika Bhatia
MBBS MD (Pathology)
Reg. No:UKMC-14474

Dr. Abhishek Baunthiyal
MBBS MD (Pathology)
Reg. No:UKMC-2884

Address: Lane C-8, Turner Road, Clement Town, Dehradun - 248002, Uttarakhand
Phone: +91 9557069086, 7817003052, 0135-3563692 • **Email:** mail@baunthiyallabs.com

**Sample has been collected outside the laboratory. The results pertain to the sample received.

BO90127 240126

LAB ID	: BO90127	**Sample Collection**	: 24/01/2026 11:48 AM
Name	: MR. SHUBHAM	**Age/Sex**	: 22 Yrs. / M	**Report Released**	: 24/01/2026 12:46 PM
Ref. By.	: SELF	**UH ID**	: B26222358	**Printed**	: 24/01/2026 12:53 PM
Sent By	: BPL-STAFF				

---------- End Of Report ----------

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INSTITUTE OF LIVER & BILIARY SCIENCES

(An Autonomous Society under Government of NCT of Delhi)

D-1, Vasant Kunj, New Delhi, India

Phone No: 011-46300000 **Ext:** 17055 & 17056, 011-26706700– 02

Liver help line -1-800-11-5354

Fax No: 46300010, **Email:** info@ilbs.in, **Website:** http://www.ilbs.in

LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: WB 6036600	**SAMPLE TYPE**	: WB PLASMA
SAMPLE COLLECTION DATE	: 24/01/2026 16:39	**SAMPLE ACCESSIONING DATE**	: 24/01/2026 16:59
Bill NO	: ER/ILBS/26/02524	**REPORT VERIFIED DATE**	: 24/01/2026 19:00
FINALISED BY	: Dr. Sherin Thomas		
WARD/BED	: EMERGENCY GROUND FLOOR -E162-7	**CASE NO**	: ER/ILBS/26/02524
ORDER DATE	: 24/01/2026 16:34	**Print Date**	: 24/01/2026 19:00

BIOCHEMISTRY

Parameter	Result	Flag	Units	Reference Range
AMMONIA-PLASMA				
AMMONIA(ENZYMATIC)	**300**	HH	µg/dl	31-123

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.Sherin Thomas
CONSULTANT- GR-III

Result Entered By : Dr. Sherin Thomas

Patient Name	**: Mr. SHUBHAM KUMAR**	Specimen Drawn ON	: 21/Jan/2026 02:23PM
Age/Gender	: 22 YRS /M	Specimen Received ON	: 21/Jan/2026 06:07PM
UHID/MR No	: ADEL.0004013522	Report Date	: 22/Jan/2026 07:34AM
Barcode No	**: D1022011**	Client Code	: DL3032
Ref Doctor	: Dr.SELF	Visit ID	: MDEL4016553
Ref Customer	: SELF	Client Name	: HAD LABS

DEPARTMENT OF BIOCHEMISTRY

HEALTH PROFILE 6.4

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST (LFT)-EXTENDED				
Sample Type : SERUM				
Bilirubin Total	**15.35**	mg/dl	<1.1	Diazotized Sulfanilic
Bilirubin Direct	**9.62**	mg/dl	0-0.3	Diazotized Sulfanilic
Bilirubin Indirect	**5.73**	mg/dl	0.30-1.00	Calculated
SGOT (AST)	**3706.9**	U/L	<31.0	IFCC without pyridoxal phosphate
SGPT (ALT)	**4883.1**	U/L	<33.0	IFCC without pyridoxal phosphate
Alkaline Phosphatase (ALP)	**321.6**	U/L	40-129	Spectrophotometry
Gamma Glutamyl Transferase (GGT)	**208.5**	U/L	15-60	L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate
Protein Total	7.2	g/dL	6.6-8.7	Biuret
Albumin (Serum)	3.59	g/dL	3.5-5.5	Bromo Cresol Green (BCG)
Globulin	**3.61**	g/dL	2.50-3.50	Calculated
A/G Ratio	**0.99**		1.5-2.5	Calculated

Interpretation:- Liver blood tests, or liver function tests, are used to detect and diagnose disease or inflammation of the liver. Elevated aminotransferase (ALT, AST) levels are measured as well as alkaline phosphatase, albumin, and bilirubin. Some diseases that cause abnormal levels of ALT and AST include hepatitis A, B, and C, cirrhosis, iron overload, and Tylenol liver damage. Medications also cause elevated liver enzymes. There are less common conditions and diseases that also cause elevated liver enzyme levels.: Liver blood tests, or liver function tests, are used to detect and diagnose disease or inflammation of the liver. Elevated aminotransferase (ALT, AST) levels are measured as well as alkaline phosphatase, albumin, and bilirubin. Some diseases that cause abnormal levels of ALT and AST include hepatitis A, B, and C, cirrhosis, iron overload, and Tylenol liver damage. Medications also cause elevated liver enzymes.There are less common conditions and diseases that also cause elevated liver enzyme levels.

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

This report has been validated by:

Pawan Kumar
DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

Neeru
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LAB HEAD
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QR CODE

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Fax No: 46300010, **Email:** info@ilbs.in, **Website:** http://www.ilbs.in

LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: Ser6036599	**SAMPLE TYPE**	: Serum
SAMPLE COLLECTION DATE	: 24/01/2026 16:38	**SAMPLE ACCESSIONING DATE**	: 24/01/2026 16:59
Bill NO	: ER/ILBS/26/02524	**REPORT VERIFIED DATE**	: 24/01/2026 19:01
FINALISED BY	: Dr. Sherin Thomas		
WARD/BED	: EMERGENCY GROUND FLOOR -E162-7	**CASE NO**	: ER/ILBS/26/02524
ORDER DATE	: 24/01/2026 16:34	**Print Date**	: 24/01/2026 19:01

BIOCHEMISTRY

Parameter	Result	Flag	Units	Reference Range	Methodology
Liver Function Test / Profile**					
BILIRUBIN TOTAL{DPD}	**18.12**	HH	mg/dl	0.2-1.1	
BILIRUBIN DIRECT{DPD}	**9.72**	H	mg/dl	0-0.2	
BILIRUBIN INDIRECT (CALCULATED)	**8.4**	HH	mg/dl	0.2-0.8	Calculated
AST/SGOT {IFCCWITHOUT P5P}	**1059**	HH	IU/L	5-40	
ALKALINE PHOSPHATASE{IFCC AMP BUFFER}	**290.9**	HH	IU/L	56-167	
GGT {IFCC}	**101.4**	HH	IU/L	0-55	
TOTAL PROTEIN{BIURET}	7.6		g/dL	6.4-8.3	
ALBUMIN {BCP BROMOCRESOL GREEN}	3.73		g/dL	3.5-5.2	
GLOBULIN (CALCULATED)	**3.87**	H	gm/dl	2-3.5	
A\G RATIO (CALCULATED)	**0.97**	L		1.5-2.5	

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.Sherin Thomas
CONSULTANT- GR-III

Result Entered By : Dr. Sherin Thomas

INSTITUTE OF LIVER & BILIARY SCIENCES

(An Autonomous Society under Government of NCT of Delhi)
D-1, Vasant Kunj, New Delhi, India
Phone No: 011-46300000 **Ext:** 17055 & 17056, 011-26706700– 02
Liver help line - 1-800-11-5354
Fax No: 46300010, **Email:** info@ilbs.in, **Website:** http://www.ilbs.in

LABORATORY REPORT

PATIENT NAME	: Mr. SHUBHAM KUMAR	**UHID**	: ILBS.0000411952
AGE/SEX	: 21Y /MALE	**REFERRING DOCTOR**	: Dr. NEHA SHARMA
SAMPLE NO	: Who6037114	**SAMPLE TYPE**	: Whole Blood
SAMPLE COLLECTION DATE	: 25/01/2026 00:45	**SAMPLE ACCESSIONING DATE**	: 25/01/2026 01:45
Bill NO	: IP/ILBS/26/05340	**REPORT VERIFIED DATE**	: 25/01/2026 02:04
FINALISED BY	: Mr. Praveen Garg		
WARD/BED	: Liver ICU Phase II -2378-01	**CASE NO**	: IP/ILBS/26/05340
ORDER DATE	: 25/01/2026 00:43	**Print Date**	: 25/01/2026 02:03

HAEMATOLOGY

Parameter	Result	Flag	Units	Reference Range	Methodology
CBC (Fully Automatic Haematology Cell Counter)**					
HAEMOGLOBIN(PHOTOMETRIC METHOD)	**11.7**	L	gm/dl	13-17	Photometric Method
PCV / HAEMATOCRIT (CALCULATED)	**32.5**	L	%	40-50	Calculated
TOTAL LEUCOCYTE COUNT TLC (IMPEDANCE METHOD)	4.51		10~9/L	4-11	Impedance Method
PLATELET COUNT (IMPEDANCE METHOD)	**134**	LL	10~9/L	150-450	Impedance Method
DIFFERENTIAL LEUKOCYTE COUNT(FLOWCYTOMETRY METHOD)					
NEUTROPHILS	**87.3**	HH	%	40-75	
LYMPHOCYTES	**11.1**	LL	%	37-79	
MONOCYTES	**0.80**	L	%	2-10	
EOSINOPHILS	**0.8**	L	%	1-6	

--- End Of Report ---

-----Report electronically verified-----

Authorized By:

Dr.CHHAGAN BIHARI
PROFESSOR

Result Entered By : Mr. Praveen Garg