Patient Name	: Ms.SATHYAVATHY D	Collected	: 12/Feb/2026 07:43AM
Age/Gender	: 83 Y 6 M 8 D /F	Received	: 12/Feb/2026 12:40PM
UHID/MR No	: APJ1.0015941385	Reported	: 12/Feb/2026 07:06PM
Visit ID	: DATPOPV41905	Status	: Final Report
Ref Doctor	: Dr.SELF	Client Name	: APOLLO 24X7
IP/OP NO	:	Center location	: Hyderguda,Hyderabad

DEPARTMENT OF HAEMATOLOGY

APOLLO VITAMIN CHECK - ADVANCE

Test Name	Result	Unit	Bio. Ref. Interval	Method
COMPLETE BLOOD COUNT (CBC) , *WHOLE BLOOD EDTA*				
HAEMOGLOBIN	**8.7**	g/dL	13-17	Spectrophotometer
PCV	**26.60**	%	36-46	Electronic pulse & Calculation
RBC COUNT	**2.9**	Million/cu.mm	3.8-4.8	Electrical Impedence
MCV	91.6	fL	83-101	Calculated
MCH	30	pg	27-32	Calculated
MCHC	32.7	g/dL	31.5-34.5	Calculated
R.D.W	**17.6**	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	**20,280**	cells/cu.mm	4000-10000	Electrical Impedance
DIFFERENTIAL LEUCOCYTIC COUNT (DLC)				
NEUTROPHILS	55	%	40-80	Flow cytometry
LYMPHOCYTES	**11**	%	20-40	Flow cytometry
EOSINOPHILS	1	%	1-6	Flow cytometry
MONOCYTES	**12**	%	2-10	Flow cytometry
BASOPHILS	2	%	0-2	Flow cytometry
BLASTS	3	%		Microscopic
MYELOCYTES	10	%		Microscopic
META-MYELOCYTE	6	%		Microscopic
NRBC s/100 WBC	6	/100 WBC		Microscopic
CORRECTED TLC	19,132	Cells/cu.mm		Calculated
ABSOLUTE LEUCOCYTE COUNT				
NEUTROPHILS	**10522.64**	Cells/cu.mm	2000-7000	Calculated
LYMPHOCYTES	2104.53	Cells/cu.mm	1000-3000	Calculated
EOSINOPHILS	191.32	Cells/cu.mm	20-500	Calculated
MONOCYTES	**2295.85**	Cells/cu.mm	200-1000	Calculated
BASOPHILS	**382.64**	Cells/cu.mm	0-100	Calculated
Neutrophil lymphocyte ratio (NLR)	**5**		0.78- 3.53	Calculated
PLATELET COUNT	**35000 (CL)**	cells/cu.mm	150000-410000	Electrical impedence
MPV	11.6	Fl	8.1-13.9	Calculated

Dr.V Sankara Aparna Akella
MBBS,DNB(Pathology)
Consultant Pathologist

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SIN No:HA10621930

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APOLLO VITAMIN CHECK - ADVANCE

Clinical history of Essential thrombocytosis on treatment,suggest clinical correlation ,follow up and bone marrow examination if clinically indicated.

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DEPARTMENT OF BIOCHEMISTRY

APOLLO VITAMIN CHECK - ADVANCE

Test Name	Result	Unit	Bio. Ref. Interval	Method
CALCIUM , *SERUM*	**8.71**	mg/dL	8.8-10.2	NM-Bapta

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Consultant Biochemist

SIN No:BM00773968

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Apollo Health and Lifestyle Limited
(CIN - U85110TG2000PLC115819)
Corporate Office: 7-1-617/A, 7th Floor, Imperial Towers, Ameerpet, Hyderabad-500016, Telangana
Ph No: 040-4904 7777 | www.apollohl.com I Email ID:enquiry@apollohl.com

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
CREATININE , *SERUM*	0.72	mg/dL	0.5-1	Jaffe

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
ELECTROLYTES - SERUM , *SERUM*				
SODIUM	137.6	mmol/L	136-145	ISE (Indirect)
POTASSIUM	3.5	mmol/L	3.5-5.1	ISE (Indirect)
CHLORIDE	102	mmol/L	98-107	ISE (Indirect)

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DEPARTMENT OF BIOCHEMISTRY

APOLLO VITAMIN CHECK - ADVANCE

Test Name	Result	Unit	Bio. Ref. Interval	Method
IRON STUDIES (IRON + TIBC) , *SERUM*				
IRON	**24.1**	µg/dL	33-193	FerroZine
TOTAL IRON BINDING CAPACITY (TIBC)	305.1	ug/dL	250-400	Dye Binding
UNSATURATED IRON BINDING CAPACITY (UIBC)	281.00	ug/dL	135-392	Direct Estimation by Ferrozine
% OF TRANSFERRIN SATURATION	**7.9**	%	14-50	Calculated

Comment:

Transferrin is the primary plasma iron transport protein, which binds iron strongly at physiological pH. Transferrin is generally only 25% to 30% saturated with iron. The additional amount of iron that can be bound is the unsaturated iron-binding capacity (UIBC). Diurnal variation is seen in serum iron levels—normal values in midmorning, low values in midafternoon, very low values (approximately 10 µg/dL) near midnight.

TIBC measures the blood's capacity to bind iron with transferrin (TRF). Estrogens and oral contraceptives increase TIBC levels. Asparaginase, chloramphenicol, corticotropin, cortisone, and testosterone decrease the TIBC levels.

% saturation represents the amount of iron-binding sites that are occupied. Iron saturation is a better index of iron stores than serum iron alone. % saturation is decreased in iron deficiency anemia (usually <10% in established deficiency).

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DEPARTMENT OF BIOCHEMISTRY

APOLLO VITAMIN CHECK - ADVANCE

Test Name	Result	Unit	Bio. Ref. Interval	Method
MAGNESIUM , *SERUM*	2.01	mg/dL	1.6-2.4	Xylidyl Blue

Comment:

- Magnesium along with potassium is a major intracellular cation. Mg2+ is a cofactor of many enzyme systems. Thus, all ATP dependent enzymatic reactions require Mg2+ as a cofactor in the ATP magnesium complex.

  Approximately 69 % of magnesium ions are stored in bone. The rest are part of the intermediary metabolism, about 70 % being present in free form while the other 30 % is bound to proteins (especially albumin), citrates, phosphate, and other complex formers.
- This assay is used for diagnosing and monitoring hypomagnesemia (magnesium deficiency) and hypermagnesemia (magnesium excess).
- ·Hypermagnesemia is found in conditions such as acute and chronic renal failure, hemolysis , magnesium excess (through drugs, mild alkali syndrome), and magnesium release from the intracellular space (rhabdomyolysis, acidosis). There is a correlation between magnesium deficiency and changes in calcium , potassium and phosphate homeostasis

Test Name	Result	Unit	Bio. Ref. Interval	Method
PHOSPHORUS, INORGANIC , *SERUM*	3.56	mg/dL	2.5-4.5	Phosphomolybdate Complex

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DEPARTMENT OF IMMUNOLOGY

APOLLO VITAMIN CHECK - ADVANCE

Test Name	Result	Unit	Bio. Ref. Interval	Method
VITAMIN D (25 - OH VITAMIN D) , *SERUM*	**20.7**	ng/mL	30-100	ECLIA

Comment:

BIOLOGICAL REFERENCE RANGES

VITAMIN D STATUS	VITAMIN D 25 HYDROXY (ng/mL)
DEFICIENCY	<10
INSUFFICIENCY	10 – 30
SUFFICIENCY	30 – 100
TOXICITY	>100

The biological function of Vitamin D is to maintain normal levels of calcium and phosphorus absorption. 25-Hydroxy vitamin D is the storage form of vitamin D. Vitamin D assists in maintaining bone health by facilitating calcium absorption. Vitamin D deficiency can also cause osteomalacia, which frequently affects elderly patients.

Vitamin D Total levels are composed of two components namely 25-Hydroxy Vitamin D2 and 25-Hydroxy Vitamin D3 both of which are converted into active forms. Vitamin D2 level corresponds with the exogenous dietary intake of Vitamin D rich foods as well as supplements. Vitamin D3 level corresponds with endogenous production as well as exogenous diet and supplements. Vitamin D from sunshine on the skin or from dietary intake is converted predominantly by the liver into 25-hydroxy vitamin D, which has a long half-life and is stored in the adipose tissue. The metabolically active form of vitamin D, 1,25-di-hydroxy vitamin D, which has a short life, is then synthesized in the kidney as needed from circulating 25-hydroxy vitamin D. The reference interval of greater than 30 ng/mL is a target value established by the Endocrine Society.

Decreased Levels:- Inadequate exposure to sunlight, Dietary deficiency, Vitamin D malabsorption, Severe Hepatocellular disease., Drugs like Anticonvulsants, Nephrotic syndrome.

Increased levels:- Vitamin D intoxication.

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DEPARTMENT OF IMMUNOLOGY

APOLLO VITAMIN CHECK - ADVANCE

Test Name	Result	Unit	Bio. Ref. Interval	Method
VITAMIN B12 , *SERUM*	**974**	pg/mL	197-771	ECLIA

Comment:

Population based data reflecting exact scenario of vitamin B12 levels in Indian population is still evolving, however, different studies reporting a deficiency in adults, pregnant women and children ranging from 16% to 77% with average of about 47%. This high incidence is attributed to vegetarian food habits of large majority of Indian population.

Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. A significant increase in RBC MCV may be an important indicator of vitamin B12 deficiency. B12 levels in the range of 150 to 190 pg/ml may not be associated with any clinical manifestations, while B12 levels below 100 pg/ml are often associated with clinical symptoms. However, for an individual based on other co-morbid conditions or other nutritional deficiency (especially folate) the manifestations can vary accordingly.

If clinical symptoms suggest deficiency, measurement of active vitamin B12, MMA and homocysteine should be considered as further workup.

Test Name	Result	Unit	Bio. Ref. Interval	Method
FERRITIN , *SERUM*	77.2	ng/mL	13-150	ECLIA

Comment:

- Ferritin estimation is useful in the diagnosis of iron deficiency anemia and iron overload.
- Increased levels seen in hemachromatosis, frequent blood transfusions with packed RBCs and alcoholic liver disease.
- Decreased levels seen in heavy menstrual bleeding, poor absorption of iron, iron deficiency anaemia and long term GI bleed.
- Ferritin is an acute phase reactant and thus may be increased with inflammation, chronic infection, liver disease, auto-immune disorders and some type of cancers. Ferritin is not used to detect or monitor these conditions.

Test Name	Result	Unit	Bio. Ref. Interval	Method
FOLIC ACID / FOLATE - SERUM , *SERUM*	5.86	ng/mL	3.89-26.8	ECLIA

Comment:

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APOLLO VITAMIN CHECK - ADVANCE

Folate levels in both serum and RBCs are used to assess folate status. The serum folate level is an indicator of recent folate intake. RBC folate is the best indicator of long-term folate stores. A low RBC folate value may indicate a prolonged folate deficiency.
Folate levels are decreased in megaloblastic anaemia, alcoholism, malnutrition, liver disease, Vitamin B12 deficiency, pregnancy, celiac disease, chronic hemodialysis. Low serum folate levels may also be seen in the absence of deficiency, and normal levels may be seen in patients with macrocytic anemia, dementia, neuropsychiatric disorders, and pregnancy disorders.
To distinguish between vitamin B12 and folate deficiency, determination of homocysteine (HCS) and methylmalonic acid (MMA) are useful. In vitamin B12 deficiency, both HCS and MMA are elevated, whereas in folate deficiency, only HCS levels are elevated.

* (CL) Critical Low

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

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9. The patient samples can be used as part of internal quality control, test verification, data analysis purposes within the testing scope of the laboratory.
10. This report is not valid for medico legal purposes. It is performed to facilitate medical diagnosis only

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