



Shree Bajrangdasbapa Arogyadham
Managed by 3D Hospicare



Neuberg  Supratech
REFERENCE LABORATORIES
(A unit of Neuberg Diagnostics Private Limited)

LABORATORY REPORT



Name : Ms RIDAFATEMA SIDATAR	Sex/Age : Female/ 8 Years	Case ID : 60701901021
Ref.By : DR.CHETAN DAVE	Dis. At :	Pt. ID :
Bill. Loc. : Camp		Pt. Loc :
Reg Date and Time : 29-Jul-2026 22:47	Sample Type :	Mobile No :
Sample Date and Time :	Sample Coll. By : non	Ref Id1 :
Report Date and Time :	Acc. Remarks : Normal	Ref Id2 :

Out of Reference Range Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Lipid Profile			
Cholesterol	202.2	mg/dL	110 - 200
Cholesterol/HDL-C	4.27		0 - 4.1
LDL Cholesterol	130.98	mg/dL	<100

Abnormal Result(s) Summary End

Note:

This summary highlights abnormal and trend results extracted from the report for quick reference.
It is for informational purposes only and does not require a doctor's signature.



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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol <i>Colorimetric, CHOD-POD</i>	H	202.2	mg/dL	110 - 200
HDL Cholesterol		47.3	mg/dL	40 - 60
Triglyceride <i>GPO-POD</i>		119.61	mg/dL	40 - 200
VLDL <i>Calculated</i>		23.92	mg/dL	10 - 40
Cholesterol/HDL-C <i>Calculated</i>	H	4.27		0 - 4.1
LDL Cholesterol <i>Calculated</i>	H	130.98	mg/dL	<100

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Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shraddha Munshi

M.D. (Pathologist)

Printed On : 31-Jul-2026 22:54

Neuberg Diagnostics Private Limited

Lab : Shree Bajrangdas Bapa Arogyadham, Panwadi Chowk,
Panwadi, Bhavnagar - 364001

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Chennai - 600096, Tamil Nadu, India. | CIN - U85300TN2017PTC114099

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Reg Date and Time : 29-Jul-2026 22:47 Sample Type : Serum,Plasma EDTA,Serum AM Mobile No :
 Sample Date and Time : 30-Jul-2026 08:53 Sample Coll. By : non Ref Id1 :
 Report Date and Time : 31-Jul-2026 19:03 Acc. Remarks : Normal Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ALT (SGPT) <i>IIFC method without pyridoxal phosphate activation</i>	29.96	U/L	0.0 - 34.0	
Sodium <i>ISE</i>	144.5	mmol/L	138 - 145	
Potassium <i>ISE</i>	4.45	mmol/L	3.4 - 4.7	
Free T4 <i>CLIA</i>	1.20	ng/dL	0.700 - 1.480	
Leutinizing Hormone <i>CMIA</i>	< 0.12	mIU/mL	Follicular phase 1.80 to 11.78 mIU/mL Mid cycle peak 7.59 to 89.08 mIU/mL Leuteal phase 0.56 to 14.00 mIU/mL Post menopausal 5.16 to 61.99 mIU/mL	

INTERPRETATIONS:

Useful as an adjunct in the evaluation of menstrual irregularities, Evaluating patients with suspected hypogonadism, Predicting ovulation, Evaluating infertility, Diagnosing pituitary disorders.

In both males and females, primary hypogonadism results in an elevation of basal follicle-stimulating hormone (FSH) and luteinizing hormone (LH) levels.

Postmenopausal LH levels are generally >40 IU/L. (Note: FSH is the preferred test to confirm menopausal status.)

FSH and LH are generally elevated in:

Primary gonadal failure, Complete testicular feminization syndrome, Precocious puberty (either idiopathic or secondary to a central nervous system lesion), Menopause, Primary ovarian hypodysfunction in females, Polycystic ovary disease in females, Primary hypogonadism in males

LH is decreased in Primary ovarian hyperfunction in females , Primary hypergonadism in males.

FSH and LH are both decreased in failure of the pituitary or hypothalamus

CAUTIONS:

No clinically significant cross-reactivity has been demonstrated with follicle-stimulating hormone, thyroid stimulating hormone, or human chorionic gonadotropin.

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedures, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results

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ACTH 7.8 pg/mL <=46
CLIA

INTERPRETATION

Adrenocorticotrophic hormone (ACTH), the primary stimulator of adrenal cortisol production, is synthesized by the pituitary in response to corticotropin-releasing hormone (CRH), which is released by the hypothalamus. Plasma ACTH and cortisol levels exhibit peaks (6-8 a.m.) and nadirs (11 p.m.). In a patient with hypocortisolism, an elevated adrenocorticotrophic hormone (ACTH) indicates primary adrenal insufficiency, whereas a value that is not elevated is consistent with secondary adrenal insufficiency from a pituitary or hypothalamic cause. In a patient with hypercortisolism (Cushing syndrome), a suppressed value is consistent with a cortisol-producing adrenal adenoma or carcinoma, primary adrenal micronodular hyperplasia, or exogenous corticosteroid use. Further diagnostic studies such as dexamethasone suppression testing, corticotropin-releasing hormone stimulation testing, petrosal sinus sampling, and imaging studies are usually necessary to define the ACTH source.

CAUTIONS

In very rare instances of the ectopic adrenocorticotrophic hormone (ACTH) syndrome, the elevated ACTH may be biologically active but not detected by the immunometric assay. Patients taking glucocorticoids may have suppressed levels of ACTH with an apparent high level of cortisol. This may be due to cross-reactivity with the cortisol immunoassays. If exogenous Cushing is suspected, a cortisol level determined by liquid chromatography-tandem mass spectrometry should be used with the ACTH level for the interpretation.

Cortisol 8 AM 7.40 µg/dL 3.7 - 19.4
CLIA

DHEA-S 121.00 µg/dL 35 - 430

Note the change in Reference range and method of testing.

INTERPRETATION:

Useful for Diagnosis and differential diagnosis of hyperandrogenism (in conjunction with measurements of other sex steroids)

An adjunct in the diagnosis of congenital adrenal hyperplasia

Diagnosis and differential diagnosis of premature adrenarche

Patients with congenital adrenal hyperplasia (CAH) may show very high levels of DHEA-S, often 5- to 10-fold elevations. However, with the possible exception of 3 beta-hydroxysteroid dehydrogenase deficiency, other steroid analytes offer better diagnostic accuracy than DHEA-S measurements.

Consequently, DHEA-S testing should not be used as the primary tool for CAH diagnosis. Similarly, discovering a high DHEA-S level in an infant or child with symptoms or signs of possible CAH should prompt additional testing, as should the discovery of very high DHEA-S levels in an adult. In the latter case, adrenal tumors need to be excluded and additional adrenal steroid profile testing may assist in diagnosing nonclassical CAH.

CAUTIONS:

There are currently no established guidelines for dehydroepiandrosterone sulfate (DHEA-S) replacement/supplementation therapy or its biochemical monitoring. In most settings, the value of DHEA-S therapy is doubtful. However, if DHEA-S therapy is used, then it seems prudent to avoid over-treatment, with its associated hyperandrogenic effects. These are particularly likely to occur in postmenopausal females if DHEA-S levels approach or exceed the upper reference range.

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
TSH (ULTRASENSITIVE)				
TSH CMIA	1.0368	µIU/mL	0.7 - 6.4	

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

For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

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