

BASHAM, ANDRONICKY NICKY
149 EGINA ST
MOUNT HAWTHORN 6016
DOB: 12/12/55 Sex: F

PATIENT'S COPY

Ref. by DR.MAYA PEATY
Collection Date: 21/02/24 11:35

Printed
22/02/24
10:30
PTN -CNT
84418509

VITAMIN B12 and FOLATE (serum)

Vitamin B12 : 366 pmol/L (< 120 Deficient)
(150-750 Normal)

Serum Folate : 30.4 nmol/L (< 5.0 Deficient)
(>= 5.0 Normal)

COMMENT: Normal vitamin B12 and folate status. Tissue deficiency is unlikely.

Patient supplementation with high dose biotin may falsely increase serum folate (Atellica assay). If concerned with the result, consider withholding biotin for 24 hours prior to repeating the test. Please contact the laboratory for further information.

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

34/944:88

Normal
File

Notes
Required

Patient
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Instrument: Siemens Atellica

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DMR_0003_4F_0323

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CUMULATIVE ELECTROLYTES (Serum)

Date	Time	Na mmol/L (135 - 145)	K mmol/L (3.5 - 5.2)	Cl mmol/L (95 - 110)	HCO3 mmol/L (22 - 32)	Urea mmol/L (3.0 - 8.0)	Creat umol/L (45 - 90)	Lab.No.
03/03/23	08:20	141	4.3	105	29	5.0	69	81483135
21/02/24	11:35	142	4.3	105	28	7.2	75	84418509

eGFR : 71 mL/min/1.73m²

EGFR by CKD-EPI formula (Med J Aust 2012; 197:222 -223).

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Instrument: Siemens Atellica

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3481_P0045_HF 16023

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GLYCATED HAEMOGLOBIN (Blood)

Date	Hb A1C %	mmol/mol (IFCC)	Lab No
03/03/23	5.3	34	81483135
21/02/24	5.2	33	84418509

Diagnostic threshold for type 2 diabetes mellitus:

$\geq 6.5\%$ (≥ 48 mmol/mol).

General treatment target for patients with known diabetes mellitus:

$\leq 7.0\%$ (≤ 53 mmol/mol). Higher or lower targets are appropriate for some patients.

See www.wdp.com.au/HbA1c for more information on the use and interpretation of HbA1c.

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DOC_P1003_HF 28/03

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ROUTINE HAEMATOLOGY (Whole Blood)

RCC	4.76	x 10 ¹² /L	HAEMOGLOBIN	133	(115 - 160)	g/L
	(3.80 - 5.80)		MCV	86	(80 - 98)	fL
HCT	0.408		MCHC	326	(315 - 360)	g/L
	(0.370 - 0.470)		RDW	15	(< 16)	%
MCH	27.9	pg				
	(27.0 - 34.0)					
			PLATELETS	244	(150 - 450)	x 10 ⁹ /L
			WHITE CELLS	5.8	(4.0 - 11.0)	x 10 ⁹ /L
			Neut	76%	4.4	(2.0 - 8.0) " "
			* Lymph	13%	0.8	(1.0 - 4.0) " "
			Mono	8%	0.5	(0.2 - 1.2) " "
			Eosin	3%	0.2	(< 0.7) " "

No significant abnormality.

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

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DOC_PTH03_HF 2003

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LIVER FUNCTION TESTS (Serum)

Total Bilirubin	:	8 umol/L	(< 16)
Alk. Phos	:	100 U/L	(30 - 110)
Gamma GT	:	11 U/L	(< 36)
ALT	:	22 U/L	(< 36)
Albumin	:	44 g/L	(36 - 48)
Total Protein	:	74 g/L	(60 - 80)

25-HYDROXY VITAMIN D (serum)

SERUM VITAMIN D STUDY

-- 25-hydroxy Vitamin D 61 nmol/L (> 50)

Instrument: Diasorin Liaison

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC 39/944:88

DOC: PH045 v4 0323

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THYROID ANTIBODIES (Serum)

Antithyroid peroxidase (TPO) : 43 IU/mL (< 60)

Instrument: Siemens Atellica

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

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Cell: 1045, 1F 18/03

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CUMULATIVE IRON STUDIES (serum)

Date	Iron umol/L	Transferrin umol/L	TFN Satn %	Ferritin ug/L	Lab.No.
21/02/24	9	28	16	55	84418509
Ref:	(11 - 27)	(20 - 45)	(15 - 55)	(30 - 300)	

84418509 Low-normal ferritin may indicate adequate iron stores, but iron deficiency is not excluded as co-existing inflammation or acute phase response may falsely raise ferritin. Correlate with clinical state.

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

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DOB: 12/12/55, IF: 00323

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- As ferritin is influenced by acute phase responses results in the lower-normal range (30-100) may not exclude iron deficiency.
- Ferritin levels >100 and < upper limit usually reflect adequate iron stores.
- Serum iron is useless in determining tissue iron stores.

Instrument: Siemens Atellica

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

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LIPIDS (Serum)

Date		Chol mmol/L (< 5.5)	Trig mmol/L (< 2.0)	HDL-C mmol/L (> 1.1)	LDL-C mmol/L (< 3.4)	Ratio (See) (Below)	Lab. No.
03/03/23	Fasting	4.5	1.1	1.9	2.1	2.4	81483135
21/02/24	Random	4.9	2.2	1.9	2.0	2.6	84418509

Coronary Risk Ratio Ref Values: Average = 4.4 Twice Average = 7.0

84418509 Non-HDL-cholesterol: 3 mmol/L (reference interval: < 4.1 mmol/L).
Lipid-related cutoffs are intended to identify patients who may benefit from overall cardiovascular risk assessment, and do not necessarily represent treatment initiation thresholds or targets, which should be individualised to the patient. See www.cvdcheck.org.au

21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

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21/02/24 Tests : TF,LPD,IRS,HAE,BF,VID,TPO,LFT,GA,EUC

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DOI: 1903_4F_0323

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CUMULATIVE THYROID FUNCTION TEST (serum)

	TSH (mIU/L) (0.40 - 4.00)	FT4 (pmol/L) (10 - 20)	FT3 (pmol/L) (3.5 - 6.5)	Lab.No.
01/11/21	3.70	14	4.2	87903680
03/03/23	5.69			81483135
21/07/23	4.42	15		81608746
21/02/24	4.04	14		84418509

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Comment

Mild, persistent increase in TSH with normal FT4 is consistent with subclinical hypothyroidism. Other causes of this pattern include inadequate thyroid hormone replacement for primary hypothyroidism, non-thyroidal illness and excessive antithyroid therapy.

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46/944:88