DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

From,

Neethu. R. das
BOB

To,

DDRC SRL
DVM.

Respected Sir/Mam,

I am not interested to do PPBS, PP
pepsomeao, X-ray, ECG, usg, G.Echo.

DDRC SRL Diagnostics Ltd
MEDICAL COLLEGE

Neethu

14/01/2023.

LABORATORY SERVICES

Patient Ref. No. 666000003024173

DDRC SRL Diagnostic Services
Cert. No. MC-2812
INDIA'S LEADING DIAGNOSTICS NETWORK

CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

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KERALA, INDIA
Tel : 93334 93334, Fax : CIN - U85190MH2006PTC161480
Email : customercare.ddrc@srl.in

PATIENT NAME : MRS NEETHU R DAS PATIENT ID : **MRSNF1401914182**

ACCESSION NO : **4182WA006632** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 14/01/2023 11:11 REPORTED : 16/01/2023 08:33

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results		Units
MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO			
*** BLOOD UREA NITROGEN (BUN), SERUM**			
BLOOD UREA NITROGEN	7	Adult(<60 yrs) : 6 to 20	mg/dL
*** BUN/CREAT RATIO**			
BUN/CREAT RATIO	9.9		
CREATININE, SERUM			
CREATININE	0.73	18 - 60 yrs : 0.6 - 1.1	mg/dL
*** GLUCOSE, POST-PRANDIAL, PLASMA**	RESULT PENDING		
GLUCOSE FASTING,FLUORIDE PLASMA			
GLUCOSE, FASTING, PLASMA	94	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
*** GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.3	Normal : 4.0 - 5.6%. Non-diabetic level : < 5.7%. Diabetic : >6.5% Glycemic control goal More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%. Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.	%
MEAN PLASMA GLUCOSE	105.4		mg/dL
*** LIPID PROFILE, SERUM**			
CHOLESTEROL	186	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	118	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	40	General range : 40-60	mg/dL

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Test Report Status **Preliminary**	**Results**		**Units**
DIRECT LDL CHOLESTEROL	134	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	**146** **High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	**4.7** **High**	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	**3.4** **High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	23.6	Desirable value : 10 - 35	mg/dL
*** LIVER FUNCTION TEST WITH GGT**			
BILIRUBIN, TOTAL	0.63	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.17	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.46	0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.5	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	3.3	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.4	General Range : 1.1 - 2.5	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	13	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	10	Adults : < 34	U/L
ALKALINE PHOSPHATASE	83	Adult (<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	15	Adult (female) : < 40	U/L
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM			
URIC ACID	4.4	Adults : 2.4-5.7	mg/dL

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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE O		
RH TYPE	POSITIVE		
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN	14.1	12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	**4.82** High	3.8 - 4.8	mil/µL
WHITE BLOOD CELL COUNT	6.78	4.0 - 10.0	thou/µL
PLATELET COUNT	375	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT	41.6	36 - 46	%
MEAN CORPUSCULAR VOL	86.3	83 - 101	fL
MEAN CORPUSCULAR HGB.	29.3	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.0	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	15.6	12.0 - 18.0	%
MENTZER INDEX	17.9		
MEAN PLATELET VOLUME	7.7	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS	44	40 - 80	%
LYMPHOCYTES	**43** High	20 - 40	%
MONOCYTES	7	2 - 10	%
EOSINOPHILS	6	1 - 6	%
BASOPHILS	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT	2.98	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	2.92	1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT	0.47	0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.41	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0.0		thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.0		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
SEDIMENTATION RATE (ESR)	18	0 - 20	mm at 1 hr
*** SUGAR URINE - POST PRANDIAL**	RESULT PENDING		
*** THYROID PANEL, SERUM**			
T3	108.60	80.00 - 200.00	ng/dL

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PATIENT NAME : MRS NEETHU R DAS PATIENT ID : **MRSNF1401914182**

ACCESSION NO : **4182WA006632** AGE : 32 Years SEX : Female ABHA NO :

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Test Report Status **Preliminary**	Results		Units
T4	9.80	5.10 - 14.10	µg/dl
TSH 3RD GENERATION	6.350	Non-Pregnant : 0.4 - 4.2 Pregnant Trimester-wise : 1st : 0.1 - 2.5 2nd : 0.2 - 3 3rd : 0.3 - 3	µIU/mL

Interpretation(s)

Triiodothyronine T3 , Thyroxine T4, and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

PHYSICAL EXAMINATION, URINE

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Test Report Status **Preliminary**	Results	Units	
COLOR	YELLOWISH		
APPEARANCE	**SLIGHTLY HAZY**		
CHEMICAL EXAMINATION, URINE			
PH	5.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.015	1.003 - 1.035	
PROTEIN	**DETECTED (TRACE)**	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	**DETECTED (++++) IN URINE**	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	**DETECTED (LARGE NOS.)**	NOT DETECTED	/HPF
WBC	**8-10**	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	NEGATIVE		
CRYSTALS	NEGATIVE		
*** SUGAR URINE - FASTING**			
SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED	
*** PHYSICAL EXAMINATION,STOOL**	RESULT PENDING		
*** CHEMICAL EXAMINATION,STOOL**	RESULT PENDING		
*** MICROSCOPIC EXAMINATION,STOOL**	RESULT PENDING		

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
- Myasthenia Gravis

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(Refer to " CONDITIONS OF REPORTING " Overleaf)

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• Muscular dystrophy

GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.

Increased in

Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.

Decreased in

Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.

NOTE:

While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.

III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.

IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don""""""""""""""""""""""t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn""""""""""""""""""""""t need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

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NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
TOTAL PROTEIN, SERUM-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 syndrome,Protein-losing enteropathy etc.
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

LABORATORY SERVICES

Patient Ref. No. 666000003024173

DDRC SRL Diagnostic Services
Cert. No. MC-2812
INDIA'S LEADING DIAGNOSTICS NETWORK

CLIENT CODE : CA00010147 - MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
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KERALA, INDIA
Tel : 93334 93334, Fax : CIN - U85190MH2006PTC161480
Email : customercare.ddrc@srl.in

PATIENT NAME : MRS NEETHU R DAS PATIENT ID : **MRSNF1401914182**

ACCESSION NO : **4182WA006632** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 14/01/2023 11:11 REPORTED : 16/01/2023 08:33

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Units

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO

*** ECG WITH REPORT**

REPORT
REPORT PENDING

*** USG ABDOMEN AND PELVIS**

REPORT
REPORT PENDING

*** CHEST X-RAY WITH REPORT**

REPORT
REPORT PENDING

*** 2D - ECHO WITH COLOR DOPPLER**

REPORT
REPORT PENDING

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

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