PATIENT NAME : ANKIT GOEL	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000138383 PROVISIONAL REPORT	ACCESSION NO : **0080WB006704** PATIENT ID : ANKIM22018280 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 41 Years Male DRAWN : RECEIVED : 18/02/2023 09:23:28 REPORTED : 18/02/2023 14:22:27

Test Report Status **Final**	Results	Biological Reference Interval	Units

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

THYROID PANEL, SERUM

T3	137.8	80.00 - 200.00	ng/dL
METHOD : COMPETITIVE (ECLIA)			
T4	9.07	5.10 - 14.10	µg/dL
METHOD : COMPETITIVE (ECLIA)			
TSH (ULTRASENSITIVE)	1.410	0.270 - 4.200	µIU/mL
METHOD : SANDWICH (ECLIA)			

Interpretation(s)

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	13.8	13.0 - 17.0	g/dL
METHOD : CYANMETHEMOGLOBIN METHOD			
RED BLOOD CELL (RBC) COUNT	4.93	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT	6.70	4.0 - 10.0	thou/µL
PLATELET COUNT	282	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	42.1	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV)	85.4	83.0 - 101.0	fL
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.9	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.7	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	**16.0 High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	17.3		
MEAN PLATELET VOLUME (MPV)	8.5	6.8 - 10.9	fL
METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	69	40 - 80	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
LYMPHOCYTES	21	20 - 40	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
MONOCYTES	9	2.0 - 10.0	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
EOSINOPHILS	1	1.0 - 6.0	%
BASOPHILS	0	0 - 1	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
ABSOLUTE NEUTROPHIL COUNT	4.62	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.41	1.0 - 3.0	thou/µL

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ABSOLUTE MONOCYTE COUNT	0.60	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.07	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	**0.00 Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.3		
METHOD : CALCULATED PARAMETER			

Interpretation(s)
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.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	**33 High**	0 - 14	mm at 1 hr

METHOD : MODIFIED WESTERGREN

Interpretation(s)
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.

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE B		
METHOD : SLIDE AGGLUTINATION			
RH TYPE	POSITIVE		
METHOD : SLIDE AGGLUTINATION			

Interpretation(s)
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.

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.3	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG)	105.4	< 116.0	mg/dL
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	85	74 - 106	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	82	Non-Diabetes 70 - 140	mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE	139	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES METHOD : ENZYMATIC ASSAY	73	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
HDL CHOLESTEROL METHOD : DIRECT MEASURE - PEG	45	< 40 Low >/=60 High	mg/dL

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CHOLESTEROL LDL	79	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	94	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	14.6	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**3.1 Low**	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	1.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			
Interpretation(s)			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.57	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)			
BILIRUBIN, DIRECT	0.19	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	0.38	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.0	6.6 - 8.7	g/dL

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METHOD : BIURET			
ALBUMIN	4.2	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			
GLOBULIN	2.8	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.5	1.0 - 2.0	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	16	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	13	0 - 41	U/L
METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE			
ALKALINE PHOSPHATASE	71	40 - 129	U/L
METHOD : PNPP - AMP BUFFER			
GAMMA GLUTAMYL TRANSFERASE (GGT)	14	8 - 61	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	149	135 - 225	U/L
METHOD : LACTATE -PYRUVATE			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	16	6 - 20	mg/dL
METHOD : UREASE - UV			
CREATININE, SERUM			
CREATININE	1.16	0.70 - 1.20	mg/dL
METHOD : ALKALINE PICRATE-KINETIC			
BUN/CREAT RATIO			
BUN/CREAT RATIO	13.79	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	6.4	3.4 - 7.0	mg/dL
METHOD : URICASE, COLORIMETRIC			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.0	6.6 - 8.7	g/dL
METHOD : BIURET			
ALBUMIN, SERUM			

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ALBUMIN	4.2	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			
GLOBULIN			
GLOBULIN	2.8	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	139	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.79	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	104	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Interpretation(s)
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
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

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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.
GLUCOSE, POST-PRANDIAL, PLASMA-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.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.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, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic 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 attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget''''s disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson''''s disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.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-inducing 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 syndrome,Protein-losing enteropathy etc.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
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
• Muscular dystrophy
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
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.
ALBUMIN, SERUM-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.

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CHANDIGARH, 160011
PUNJAB, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

Patient Ref. No. 80000001383068

PATIENT NAME : ANKIT GOEL	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000138383 PROVISIONAL REPORT	ACCESSION NO : **0080WB006704** PATIENT ID : ANKIM22018280 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :41 Years Male DRAWN : RECEIVED :18/02/2023 09:23:28 REPORTED :18/02/2023 14:22:27

Test Report Status **Final**	Results	Biological Reference Interval	Units

CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
SPECIFIC GRAVITY	1.020	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (PKA CHANGE OF PRETREATED POLY ELECTROLYTES)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (PROTEIN-ERROR-OF-INDICATORS PRINCIPLE)			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY(GLUCOSE OXIDAE/PEROXIDASE METHOD)			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (SODIUM NITROPRUSSIDE REACTION)			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (PEROXIDASE METHOD)			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - EHRLICH REACTION			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		

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METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)

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Test Report Status **Final**	Results	Biological Reference Interval	Units

CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

PHYSICAL EXAMINATION,STOOL

COLOUR	SAMPLE NOT RECEIVED		

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

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