Patient Ref. No. 666000002280211

Cert. No. MC-2812

CLIENT CODE : CA00010147 - MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

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

PATIENT NAME : MR VIKAS ABHIMANYU KUTE PATIENT ID : **MRVIM1211884182**

ACCESSION NO : **4182VK005107** AGE : 34 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 12/11/2022 10:24 REPORTED : 14/11/2022 07:45

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

MEDIWHEEL HEALTH CHECKUP BELOW 40(M)2DECHO

OPTHAL

OPTHAL		REPORT ATTACHED	

*** PHYSICAL EXAMINATION**

PHYSICAL EXAMINATION		REPORT ATTACHED	

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MEDIWHEEL HEALTH CHECKUP BELOW 40(M)2DECHO

*** BUN/CREAT RATIO**

BUN/CREAT RATIO	6.9		

CREATININE, SERUM

CREATININE	0.85	18 - 60 yrs : 0.9 - 1.3	mg/dL

*** GLUCOSE, POST-PRANDIAL, PLASMA**

GLUCOSE, POST-PRANDIAL, PLASMA	83	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA	89	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL

*** GLYCOSYLATED HEMOGLOBIN, 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

*** CORONARY RISK PROFILE (LIPID PROFILE), SERUM**

CHOLESTEROL	175	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	99	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	43	General range : 40-60	mg/dL

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DIRECT LDL CHOLESTEROL	120		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	**132**	**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	4.1		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	2.8		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	19.8		Desirable value : 10 - 35	mg/dL
*** LIVER FUNCTION TEST WITH GGT**				
BILIRUBIN, TOTAL	0.76		< 1.1	mg/dL
BILIRUBIN, DIRECT	0.28		General Range : < 0.2	mg/dL
BILIRUBIN, INDIRECT	0.48		0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.2		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.6		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.5		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.8		1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	23		Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	31		Adults : < 45	U/L
ALKALINE PHOSPHATASE	71		Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	13		Adult (Male) : < 60	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.2		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM				
URIC ACID	5.5		Adults : 3.4-7	mg/dL

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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE B		
RH TYPE	POSITIVE		
BLOOD COUNTS			
HEMOGLOBIN	16.9	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.46	4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	4.59	4.0 - 10.0	thou/µL
PLATELET COUNT	159	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT	49.1	40 - 50	%
MEAN CORPUSCULAR VOL	89.9	83 - 101	fL
MEAN CORPUSCULAR HGB.	30.9	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.4	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	13.9	12.0 - 18.0	%
MEAN PLATELET VOLUME	8.3	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR			
SEGMENTED NEUTROPHILS	47	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	2.16	2.0 - 7.0	thou/µL
LYMPHOCYTES	32	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	1.47	1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.5		
EOSINOPHILS	**12** **High**	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	**0.55** **High**	0.02 - 0.50	thou/µL
MONOCYTES	8	2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.37	0.20 - 1.00	thou/µL
BASOPHILS	1	0 - 2	%
ABSOLUTE BASOPHIL COUNT	0.0		thou/µL
ERYTHRO SEDIMENTATION RATE, BLOOD			
SEDIMENTATION RATE (ESR)	1	0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING		
*** SUGAR URINE - POST PRANDIAL**			
SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
*** THYROID PANEL, SERUM**			

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T3	133.10	80 - 200	ng/dL
T4	7.63	5.1 - 14.1	µg/dl
TSH 3RD GENERATION	1.620	21-50 yrs : 0.4 - 4.2	µIU/mL
URINE ANALYSIS			
COLOR	YELLOWISH		
APPEARANCE	CLEAR		
PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.011	1.003 - 1.035	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
NITRITE	NEGATIVE	NOT DETECTED	
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NEGATIVE		
REMARKS	NIL		
CHEMICAL EXAMINATION, URINE			
PROTEIN	NEGATIVE	NOT DETECTED	
GLUCOSE	NEGATIVE	NOT DETECTED	
KETONES	NEGATIVE	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
MICROSCOPIC EXAMINATION, URINE			
WBC	0-1	0-5	/HPF
RED BLOOD CELLS	NEGATIVE	0-5	/HPF
CRYSTALS	NEGATIVE		
*** SUGAR URINE - FASTING**			
SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED	

Interpretation(s)
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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• Muscular dystrophy
GLUCOSE, POST-PRANDIAL, PLASMA-
ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
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
CORONARY RISK PROFILE (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.

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

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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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
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)

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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 - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects 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.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

Scan to View Details

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Patient Ref. No. 666000002280211

Cert. No. MC-2812

CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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SOUTH DELHI, DELHI,
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PATIENT NAME : MR VIKAS ABHIMANYU KUTE PATIENT ID : **MRVIM1211884182**

ACCESSION NO : **4182VK005107** AGE : 34 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 12/11/2022 10:24 REPORTED : 14/11/2022 07:45

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Units

MEDIWHEEL HEALTH CHECKUP BELOW 40(M)2DECHO

*** ECG WITH REPORT**

REPORT
REPORT GIVEN

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

REPORT
REPORT GIVEN

*** USG ABDOMEN AND PELVIS**

REPORT
REPORT GIVEN

*** CHEST X-RAY WITH REPORT**

REPORT
REPORT GIVEN

****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.

BABU K MATHEW
HOD -BIOCHEMISTRY

DR.VAISHALI RAJAN
HOD - HAEMATOLOGY

PADMANABHAN NAIR
HOD - HORMONES

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