**DIAGNOSTIC REPORT**

Patient Ref. No. 775000001791712

Cert. No. MC-3003

**CLIENT CODE :** C000138369

**CLIENT'S NAME AND ADDRESS :**
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
LEGEND CRYSTAL,SHOP NO-6,GROUND & 1ST FLOOR,PLOT NO-1-7-79/A B:,PRENDERGHAST ROAD
SECUNDERABAD, 500003
TELANGANA, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : customercare.hyderabad@srl.in

**PATIENT NAME : SHANGATI MAYURI** PATIENT ID : **SHANF29029242**

ACCESSION NO : **0042VJ004127** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 28/10/2022 10:16 REPORTED : 29/10/2022 12:27

**REFERRING DOCTOR :** SELF CLIENT PATIENT ID :

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|---|---|---|---|---|
| **MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE** | | | | |
| **BLOOD COUNTS,EDTA WHOLE BLOOD** | | | | |
| HEMOGLOBIN (HB) | **10.9** | **Low** | 12.0 - 15.0 | g/dL |
| METHOD : CYANMETHEMOGLOBIN METHOD | | | | |
| RED BLOOD CELL (RBC) COUNT | 4.36 | | 3.8 - 4.8 | mil/µL |
| METHOD : ELECTRICAL IMPEDANCE | | | | |
| WHITE BLOOD CELL (WBC) COUNT | 7.40 | | 4.0 - 10.0 | thou/µL |
| METHOD : ELECTRICAL IMPEDANCE | | | | |
| PLATELET COUNT | 297 | | 150 - 410 | thou/µL |
| METHOD : ELECTRICAL IMPEDANCE | | | | |
| **RBC AND PLATELET INDICES** | | | | |
| HEMATOCRIT (PCV) | **33.7** | **Low** | 36 - 46 | % |
| METHOD : CALCULATED PARAMETER | | | | |
| MEAN CORPUSCULAR VOLUME (MCV) | **77.0** | **Low** | 83 - 101 | fL |
| METHOD : CALCULATED PARAMETER | | | | |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) | **25.0** | **Low** | 27.0 - 32.0 | pg |
| METHOD : CALCULATED PARAMETER | | | | |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) | 32.4 | | 31.5 - 34.5 | g/dL |
| METHOD : CALCULATED PARAMETER | | | | |
| RED CELL DISTRIBUTION WIDTH (RDW) | **15.2** | **High** | 11.6 - 14.0 | % |
| METHOD : CALCULATED PARAMETER | | | | |
| MENTZER INDEX | 17.7 | | | |
| MEAN PLATELET VOLUME (MPV) | 9.0 | | 6.8 - 10.9 | fL |
| METHOD : CALCULATED PARAMETER | | | | |
| **WBC DIFFERENTIAL COUNT** | | | | |
| NEUTROPHILS | 54 | | 40 - 80 | % |
| METHOD : ACV TECHNOLOGY | | | | |
| LYMPHOCYTES | **41** | **High** | 20 - 40 | % |
| METHOD : ACV TECHNOLOGY | | | | |
| MONOCYTES | 3 | | 2 - 10 | % |
| METHOD : ACV TECHNOLOGY | | | | |
| EOSINOPHILS | 2 | | 1 - 6 | % |
| METHOD : ACV TECHNOLOGY | | | | |
| BASOPHILS | 0 | | 0 - 2 | % |
| METHOD : ACV TECHNOLOGY | | | | |



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| ABSOLUTE NEUTROPHIL COUNT | 4.00 | | 2.0 - 7.0 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE LYMPHOCYTE COUNT | **3.03** | **High** | 1.0 - 3.0 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE MONOCYTE COUNT | 0.22 | | 0.2 - 1.0 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE EOSINOPHIL COUNT | 0.15 | | 0.02 - 0.50 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE BASOPHIL COUNT | **0** | **Low** | 0.02 - 0.10 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 1.3 | | | |
| METHOD : CALCULATED | | | | |
| **MORPHOLOGY** | | | | |
| RBC | NORMOCYTIC NORMOCHROMIC WITH FEW MICROCYTES, ANISOCYTOSIS. | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| WBC | RELATIVE LYMPHOCYTOSIS. | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| PLATELETS | ADEQUATE ON SMEAR. | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| **ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD** | | | | |
| E.S.R | 12 | | 0 - 20 | mm at 1 hr |
| METHOD : WESTERGREN METHOD | | | | |
| **GLUCOSE FASTING,FLUORIDE PLASMA** | | | | |
| FBS (FASTING BLOOD SUGAR) | 92 | | 74 - 99 | mg/dL |
| METHOD : SPECTROPHOTOMETRY HEXOKINASE | | | | |
| **GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD** | | | | |
| HBA1C | 5.4 | | Non-diabetic: < 5.7<br>Pre-diabetics: 5.7 - 6.4<br>Diabetics: > or = 6.5<br>ADA Target: 7.0<br>Action suggested: > 8.0 | % |
| METHOD : ION- EXCHANGE HPLC | | | | |
| ESTIMATED AVERAGE GLUCOSE(EAG) | 108.3 | | < 116.0 | mg/dL |
| METHOD : ION- EXCHANGE HPLC | | | | |



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| **GLUCOSE, POST-PRANDIAL, PLASMA** | | | | |
| PPBS(POST PRANDIAL BLOOD SUGAR) | 117 | | 70 - 139 | mg/dL |
| METHOD : SPECTROPHOTOMETRY HEXOKINASE | | | | |
| **CORONARY RISK PROFILE, SERUM** | | | | |
| CHOLESTEROL, TOTAL | 150 | | < 200 Desirable<br>200 - 239 Borderline High<br>>/= 240 High | mg/dL |
| METHOD : SPECTROPHOTOMETRY,CHOLESTEROL OXIDASE ESTERASE PEROXIDASE | | | | |
| TRIGLYCERIDES | 52 | | < 150 Normal<br>150 - 199 Borderline High<br>200 - 499 High<br>>/=500 Very High | mg/dL |
| METHOD : SPECTROPHOTOMETRY, LIPASE | | | | |
| HDL CHOLESTEROL | 49 | | < 40 Low<br>>/=60 High | mg/dL |
| METHOD : SPECTROPHOTOMETRY,POLYANIONIC DETERGENT/CHOD | | | | |
| CHOLESTEROL LDL | 91 | | < 100 Optimal<br>100 - 129<br>Near optimal/ above optimal<br>130 - 159<br>Borderline High<br>160 - 189 High<br>>/= 190 Very High | mg/dL |
| NON HDL CHOLESTEROL | 101 | | Desirable: Less than 130<br>Above Desirable: 130 - 159<br>Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | mg/dL |
| CHOL/HDL RATIO | **3.1** | **Low** | 3.3 - 4.4<br>Low Risk<br>4.5 - 7.0<br>Average Risk<br>7.1 - 11.0<br>Moderate Risk<br>> 11.0<br>High Risk | |
| LDL/HDL RATIO | 1.9 | | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |
| VERY LOW DENSITY LIPOPROTEIN | 10.4 | | </= 30.0 | mg/dL |
| **LIVER FUNCTION PROFILE, SERUM** | | | | |
| BILIRUBIN, TOTAL | 0.20 | | 0.2 - 1.0 | mg/dL |
| METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF | | | | |
| BILIRUBIN, DIRECT | 0.08 | | 0.0 - 0.2 | mg/dL |



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| METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF | | | | |
| BILIRUBIN, INDIRECT | 0.12 | | 0.1 - 1.0 | mg/dL |
| METHOD : SPECTROPHOTOMETRY,CALCULATED | | | | |
| 2 | 6.9 | | 6.4 - 8.2 | g/dL |
| METHOD : SPECTROPHOTOMETRY, MODIFIED BIURET | | | | |
| ALBUMIN | 3.4 | | 3.4 - 5.0 | g/dL |
| METHOD : SPECTROPHOTOMETRY, BCP - DYE BINDING | | | | |
| GLOBULIN | 3.5 | | 2.0 - 4.1 | g/dL |
| METHOD : SPECTROPHOTOMETRY,CALCULATED | | | | |
| ALBUMIN/GLOBULIN RATIO | 1.0 | | 1.0 - 2.1 | RATIO |
| METHOD : SPECTROPHOTOMETRY,CALCULATED | | | | |
| ASPARTATE AMINOTRANSFERASE (AST/SGOT) | **11** | **Low** | 15 - 37 | U/L |
| METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL -5-PHOSPHATE | | | | |
| ALANINE AMINOTRANSFERASE (ALT/SGPT) | 24 | | < 34.0 | U/L |
| METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL -5-PHOSPHATE | | | | |
| ALKALINE PHOSPHATASE | 71 | | 30 - 120 | U/L |
| METHOD : SPECTROPHOTOMETRY, P-NPP (AMP BUFFER) | | | | |
| GAMMA GLUTAMYL TRANSFERASE (GGT) | 18 | | 5 - 55 | U/L |
| METHOD : SPECTROPHOTOMETRY, G-GLUTAMYL-CARBOXY-NITRONILIDE | | | | |
| LACTATE DEHYDROGENASE | 170 | | 100 - 190 | U/L |
| METHOD : SPECTROPHOTOMETRY, MODIFIED ENZYMATIC LACTATE - PYRUVATE | | | | |
| **BLOOD UREA NITROGEN (BUN), SERUM** | | | | |
| BLOOD UREA NITROGEN | 11 | | 6 - 20 | mg/dL |
| METHOD : SPECTROPHOTOMETRY, UREASE UV | | | | |
| **CREATININE, SERUM** | | | | |
| CREATININE | 0.75 | | 0.60 - 1.10 | mg/dL |
| METHOD : SPECTROPHOTOMETRY, ALKALINE PICRATE KINETIC JAFFE'S | | | | |
| *** BUN/CREAT RATIO** | | | | |
| BUN/CREAT RATIO | 14.67 | | 5.00 - 15.00 | |
| METHOD : SPECTROPHOTOMETRY,CALCULATED | | | | |
| **URIC ACID, SERUM** | | | | |
| URIC ACID | 3.8 | | 2.6 - 6.0 | mg/dL |
| METHOD : SPECTROPHOTOMETRY, URICASE | | | | |
| **TOTAL PROTEIN, SERUM** | | | | |
| TOTAL PROTEIN | 6.9 | | 6.4 - 8.2 | g/dL |
| METHOD : SPECTROPHOTOMETRY, MODIFIED BIURET | | | | |
| **ALBUMIN, SERUM** | | | | |

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| ALBUMIN | 3.4 | 3.4 - 5.0 | g/dL |
| METHOD : SPECTROPHOTOMETRY, BCP - DYE BINDING | | | |
| *** GLOBULIN** | | | |
| GLOBULIN | 3.5 | 2.0 - 4.1 | g/dL |
| METHOD : SPECTROPHOTOMETRY,CALCULATED | | | |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | |
| SODIUM | 138 | 136 - 145 | mmol/L |
| METHOD : INTEGRATED MULTISENSOR TECHNOLOGY-INDIRECT | | | |
| POTASSIUM | 4.12 | 3.50 - 5.10 | mmol/L |
| METHOD : INTEGRATED MULTISENSOR TECHNOLOGY-INDIRECT | | | |
| CHLORIDE | 101 | 98 - 107 | mmol/L |
| METHOD : INTEGRATED MULTISENSOR TECHNOLOGY-INDIRECT | | | |
| **PHYSICAL EXAMINATION, URINE** | | | |
| COLOR | PALE YELLOW | | |
| METHOD : MANUAL | | | |
| APPEARANCE | CLEAR | | |
| METHOD : MANUAL | | | |
| SPECIFIC GRAVITY | 1.020 | 1.003 - 1.035 | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| **CHEMICAL EXAMINATION, URINE** | | | |
| PH | 6.0 | 4.7 - 7.5 | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| PROTEIN | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| GLUCOSE | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| KETONES | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| BLOOD | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| UROBILINOGEN | NORMAL | NORMAL | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| NITRITE | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY | | | |
| LEUKOCYTE ESTERASE | NOT DETECTED | NOT DETECTED | |



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| **MICROSCOPIC EXAMINATION, URINE** | | | | |
| PUS CELL (WBC'S) | 1-2 | | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| EPITHELIAL CELLS | 2-3 | | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| ERYTHROCYTES (RBC'S) | NOT DETECTED | | NOT DETECTED | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| CASTS | NOT DETECTED | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| CRYSTALS | NOT DETECTED | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| BACTERIA | NOT DETECTED | | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| YEAST | NOT DETECTED | | NOT DETECTED | |

**Comments**

NOTE : URINE MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINE SEDIMENT.

| | | | | |
|---|---|---|---|---|
| **THYROID PANEL, SERUM** | | | | |
| T3 | **200.30** | **High** | 80.00 - 200.00 | ng/dL |
| T4 | 10.17 | | 5.10 - 14.10 | µg/dL |
| TSH 3RD GENERATION | 1.150 | | 0.270 - 4.200 | µIU/mL |

| | |
|---|---|
| *** PAPANICOLAOU SMEAR** | |
| TEST METHOD | CONVENTIONAL GYNEC CYTOLOGY |
| SPECIMEN TYPE | TWO UNSTAINED CERVICAL SMEARS RECEIVED |
| REPORTING SYSTEM | 2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY |
| SPECIMEN ADEQUACY | SMEAR IS SATISFACTORY FOR EVALUATION WITH ABSENCE OF ENDOCERVICAL CELLS. |
| MICROSCOPY | SMEAR STUDIED REVEAL SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS.<br>NO EVIDENCE OF MALIGNANCY/FUNGAL ELEMENTS NOTED. |
| INTERPRETATION / RESULT | NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY. |

**Comments**

NOTE:1. PLEASE NOTE PAPANICOLAOU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS,HENCE SHOULD BE INTERPRETED WITH CAUTION.
2. NO CYTOLOGIC EVIDENCE OF HPV INFECTION IN THE SMEAR STUDIED.



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| **STOOL: OVA & PARASITE** | | | |
| COLOUR | BROWN | | |
| CONSISTENCY | SEMI FORMED | | |
| ODOUR | FOUL | | |
| MUCUS | NOT DETECTED | NOT DETECTED | |
| VISIBLE BLOOD | ABSENT | ABSENT | |
| POLYMORPHONUCLEAR LEUKOCYTES | 2 - 3 | 0 - 5 | /HPF |
| RED BLOOD CELLS | NOT DETECTED | NOT DETECTED | /HPF |
| MACROPHAGES | NOT DETECTED | NOT DETECTED | |
| CHARCOT-LEYDEN CRYSTALS | NOT DETECTED | NOT DETECTED | |
| TROPHOZOITES | NOT DETECTED | NOT DETECTED | |
| CYSTS | NOT DETECTED | NOT DETECTED | |
| OVA | NOT DETECTED | | |
| LARVAE | NOT DETECTED | NOT DETECTED | |
| ADULT PARASITE | NOT DETECTED | | |
| OCCULT BLOOD | NOT DETECTED | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| **ABO GROUP & RH TYPE, EDTA WHOLE BLOOD** | | | |
| ABO GROUP | TYPE O | | |
| METHOD : TUBE AGGLUTINATION | | | |
| RH TYPE | POSITIVE | | |
| METHOD : TUBE AGGLUTINATION | | | |
| *** XRAY-CHEST** | | | |
| »» | BOTH THE LUNG FIELDS ARE CLEAR | | |
| »» | BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR | | |
| »» | BOTH THE HILA ARE NORMAL | | |
| »» | CARDIAC AND AORTIC SHADOWS APPEAR NORMAL | | |
| »» | BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL | | |
| »» | VISUALIZED BONY THORAX IS NORMAL | | |
| IMPRESSION | NO ABNORMALITY DETECTED | | |
| **TMT OR ECHO** | | | |
| TMT OR ECHO | 2D ECHO TEST IS DONE RESULT NEGATIVE | | |
| *** ECG** | | | |
| ECG | WITHIN NORMAL LIMITS | | |



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CIN - U74899PB1995PLC045956
Email : customercare.hyderabad@srl.in

**PATIENT NAME : SHANGATI MAYURI** PATIENT ID : **SHANF29029242**

ACCESSION NO : **0042VJ004127** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 28/10/2022 10:16 REPORTED : 29/10/2022 12:27

**REFERRING DOCTOR :** SELF CLIENT PATIENT ID :

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| *** MEDICAL HISTORY** | | | |
| RELEVANT PRESENT HISTORY | NOT SIGNIFICANT | | |
| RELEVANT PAST HISTORY | NOT SIGNIFICANT | | |
| RELEVANT PERSONAL HISTORY | NOT SIGNIFICANT | | |
| RELEVANT FAMILY HISTORY | NOT SIGNIFICANT | | |
| OCCUPATIONAL HISTORY | NOT SIGNIFICANT | | |
| HISTORY OF MEDICATIONS | NOT SIGNIFICANT | | |
| *** ANTHROPOMETRIC DATA & BMI** | | | |
| HEIGHT IN METERS | 1.49 | | mts |
| WEIGHT IN KGS. | 65 | | Kgs |
| BMI | 29 | BMI & Weight Status as follows:<br>Below 18.5: Underweight<br>18.5 - 24.9: Normal<br>25.0 - 29.9: Overweight<br>30.0 and Above: Obese | kg/sqmts |
| *** GENERAL EXAMINATION** | | | |
| MENTAL / EMOTIONAL STATE | NORMAL | | |
| PHYSICAL ATTITUDE | NORMAL | | |
| GENERAL APPEARANCE / NUTRITIONAL STATUS | HEALTHY | | |
| BUILT / SKELETAL FRAMEWORK | AVERAGE | | |
| FACIAL APPEARANCE | NORMAL | | |
| SKIN | NORMAL | | |
| UPPER LIMB | NORMAL | | |
| LOWER LIMB | NORMAL | | |
| NECK | NORMAL | | |
| NECK LYMPHATICS / SALIVARY GLANDS | NOT ENLARGED OR TENDER | | |
| THYROID GLAND | NOT ENLARGED | | |
| CAROTID PULSATION | NORMAL | | |
| BREAST (FOR FEMALES) | NORMAL | | |
| TEMPERATURE | NORMAL | | |
| PULSE | 74/REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT | | |
| RESPIRATORY RATE | NORMAL | | |
| *** CARDIOVASCULAR SYSTEM** | | | |
| BP | 110/80 MM HG (SITTING) | | mm/Hg |



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| PERICARDIUM | NORMAL | | |
| APEX BEAT | NORMAL | | |
| HEART SOUNDS | NORMAL | | |
| MURMURS | ABSENT | | |
| *** RESPIRATORY SYSTEM** | | | |
| SIZE AND SHAPE OF CHEST | NORMAL | | |
| MOVEMENTS OF CHEST | SYMMETRICAL | | |
| BREATH SOUNDS INTENSITY | NORMAL | | |
| BREATH SOUNDS QUALITY | VESICULAR (NORMAL) | | |
| ADDED SOUNDS | ABSENT | | |
| *** PER ABDOMEN** | | | |
| APPEARANCE | NORMAL | | |
| VENOUS PROMINENCE | ABSENT | | |
| LIVER | NOT PALPABLE | | |
| SPLEEN | NOT PALPABLE | | |
| HERNIA | ABSENT | | |
| *** CENTRAL NERVOUS SYSTEM** | | | |
| HIGHER FUNCTIONS | NORMAL | | |
| CRANIAL NERVES | NORMAL | | |
| CEREBELLAR FUNCTIONS | NORMAL | | |
| SENSORY SYSTEM | NORMAL | | |
| MOTOR SYSTEM | NORMAL | | |
| REFLEXES | NORMAL | | |
| *** MUSCULOSKELETAL SYSTEM** | | | |
| SPINE | NORMAL | | |
| JOINTS | NORMAL | | |
| *** BASIC EYE EXAMINATION** | | | |
| CONJUNCTIVA | NORMAL | | |
| EYELIDS | NORMAL | | |
| EYE MOVEMENTS | NORMAL | | |
| CORNEA | NORMAL | | |
| DISTANT VISION RIGHT EYE WITHOUT GLASSES | 6/12 | | |
| DISTANT VISION LEFT EYE WITHOUT GLASSES | 6/12 | | |

**DIAGNOSTIC REPORT**

Patient Ref. No. 775000001791712

Cert. No. MC-3003

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| NEAR VISION RIGHT EYE WITHOUT GLASSES | WITHIN NORMAL LIMIT | | |
| NEAR VISION LEFT EYE WITHOUT GLASSES | WITHIN NORMAL LIMIT | | |
| COLOUR VISION | NORMAL | | |
| *** BASIC ENT EXAMINATION** | | | |
| EXTERNAL EAR CANAL | NORMAL | | |
| TYMPANIC MEMBRANE | NORMAL | | |
| NOSE | NO ABNORMALITY DETECTED | | |
| SINUSES | NORMAL | | |
| THROAT | NO ABNORMALITY DETECTED | | |
| TONSILS | NOT ENLARGED | | |
| *** BASIC DENTAL EXAMINATION** | | | |
| TEETH | NORMAL | | |
| GUMS | HEALTHY | | |
| *** SUMMARY** | | | |
| RELEVANT HISTORY | NOT SIGNIFICANT | | |
| RELEVANT GP EXAMINATION FINDINGS | NOT SIGNIFICANT | | |
| RELEVANT LAB INVESTIGATIONS | HB-10.9, LYMPHO-41. | | |
| RELEVANT NON PATHOLOGY DIAGNOSTICS | OVERWEIGHT. | | |
| REMARKS / RECOMMENDATIONS | AVOID OILY AND JUNK FOODS.PHYSICAL EXCERCISES ARE SUGGEST. ADVICE TO FOLLOW UP WITH PHYSICIAN FOR ANEMIA WORKUP. HAVE IRON RICH DIET. ADVICE TO FOLLOWUP WITH PHYSICIAN IF SYMPTOMATIC FOR LYMPHOCYTOSIS. | | |
| *** FITNESS STATUS** | | | |
| FITNESS STATUS | FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS) | | |

**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.
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



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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.

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:**

Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.

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

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



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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'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
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



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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.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
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
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
STOOL: OVA & PARASITE-
Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

**DIAGNOSTIC REPORT**

Patient Ref. No. 775000001791712

Cert. No. MC-3003

**CLIENT CODE :** C000138369

**CLIENT'S NAME AND ADDRESS :**
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
LEGEND CRYSTAL,SHOP NO-6,GROUND & 1ST FLOOR,PLOT NO-1-7-79/A B:,PRENDERGHAST ROAD
SECUNDERABAD, 500003
TELANGANA, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : customercare.hyderabad@srl.in

**PATIENT NAME : SHANGATI MAYURI** PATIENT ID : **SHANF29029242**

ACCESSION NO : **0042VJ004127** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 28/10/2022 10:16 REPORTED : 29/10/2022 12:27

**REFERRING DOCTOR :** SELF CLIENT PATIENT ID :

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

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.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

**********
FITNESS STATUS-
Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.
Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:
• Fit (As per requested panel of tests) – SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
• Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
• Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.



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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

*** ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

NO ABNORMALITIES DETECTED

****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.**

**Dr M. Prasanthi**
**Consultant Microbiologist**

**Dr. Ravi Teja J**
**Consultant Pathologist**

**CONDITIONS OF LABORATORY TESTING & REPORTING**

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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**SRL Limited**
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062



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