



CLIENT CODE : C000138361

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
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NEW DELHI, 110092
NEW DELHI, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : wellness.eastdelhi@srl.in

PATIENT NAME : SHUBHAM ATRI

PATIENT ID : SHUBM20089128

ACCESSION NO : 0028WB00033 AGE : 31 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 11/02/2023 09:06

REPORTED : 13/02/2023 12:27

REFERRING DOCTOR : SELF

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Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	15.5	13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	5.70	High 4.5 - 5.5	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	7.80	4.0 - 10.0	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	203	150 - 410	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	48.0	40.0 - 50.0	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	84.1	83.0 - 101.0	fL
METHOD : DERIVED/COULTER PRINCIPLE			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.1	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.2	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.9	11.6 - 14.0	%
METHOD : DERIVED/COULTER PRINCIPLE			
MENTZER INDEX	14.8		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	11.5	High 6.8 - 10.9	fL
METHOD : DERIVED/COULTER PRINCIPLE			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	59	40 - 80	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
LYMPHOCYTES	27	20 - 40	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
MONOCYTES	8	2.0 - 10.0	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
EOSINOPHILS	5	1.0 - 6.0	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			
BASOPHILS	1	0 - 1	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY			



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ABSOLUTE NEUTROPHIL COUNT		4.70	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.10	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.60	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.39	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.08	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.2		
METHOD : CALCULATED PARAMETER				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R		3	< 15	mm at 1 hr
METHOD : MODIFIED WESTERGRENN METHOD BY AUTOMATED ANALYSER				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		87	74 - 106	mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.1	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)	%
METHOD : HPLC				
ESTIMATED AVERAGE GLUCOSE(EAG)		99.7	< 116.0	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)		81	Non-Diabetes 70 - 140	mg/dL
METHOD : HEXOKINASE				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL		139	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE				



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TRIGLYCERIDES	123		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
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METHOD : ENZYMATIC, END POINT

HDL CHOLESTEROL	35	Low	< 40 Low >/=60 High	mg/dL
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METHOD : DIRECT MEASURE POLYMER-POLYANION

CHOLESTEROL LDL	79		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
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NON HDL CHOLESTEROL	104		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
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METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN	24.6		Desirable value : 10 - 35	mg/dL
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CHOL/HDL RATIO	4.0		3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
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LDL/HDL RATIO	2.3		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
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Interpretation(s)

- 1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.
- 2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.
- 3) HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL
- 4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis. The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.
- 5) Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A. CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)



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Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.41		UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)				
BILIRUBIN, DIRECT	0.12		0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION				
BILIRUBIN, INDIRECT	0.29		0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	7.6		6.6 - 8.7	g/dL
METHOD : BIURET,SERUM BLANK,ENDPOINT				
ALBUMIN	4.6		3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN	3.0		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)	32		0 - 40	U/L
METHOD : UV WITHOUT P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	58	High	0 - 41	U/L
METHOD : UV WITHOUT P5P				
ALKALINE PHOSPHATASE	80		40 - 129	U/L
METHOD : PNPP, AMP BUFFER-IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	25		8 - 61	U/L
METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC				
LACTATE DEHYDROGENASE	186		135 - 225	U/L
METHOD : L TO P, IFCC				





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BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	9	6 - 20	mg/dL
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METHOD : UREASE - UV

CREATININE, SERUM

CREATININE	0.79	0.70 - 1.20	mg/dL
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METHOD : ALKALINE PICRATE-KINETIC

BUN/CREAT RATIO

BUN/CREAT RATIO	11.39	5.00 - 15.00	
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METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID	5.2	3.4 - 7.0	mg/dL
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METHOD : URICASE, COLORIMETRIC

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.6	6.6 - 8.7	g/dL
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METHOD : BIURET,SERUM BLANK,ENDPOINT

ALBUMIN, SERUM

ALBUMIN	4.6	3.97 - 4.94	g/dL
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METHOD : BROMOCRESOL GREEN

GLOBULIN

GLOBULIN	3.0	2.0 - 4.0	g/dL
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Neonates -
Pre Mature:
0.29 - 1.04

METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	140	136 - 145	mmol/L
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METHOD : ISE INDIRECT

POTASSIUM, SERUM	4.11	3.5 - 5.1	mmol/L
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METHOD : ISE INDIRECT

CHLORIDE, SERUM	101	98 - 107	mmol/L
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METHOD : ISE INDIRECT



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Interpretation(s)

Sodium	Potassium	Chloride
Decreased in: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, antidepressants (SSRI), antipsychotics.	Decreased in: Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.	Decreased in: Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	Increased in: Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison's disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium-sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	Increased in: Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO ₃ ⁻), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemia, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	Interferences: Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	Interferences: Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

METHOD : VISUAL

APPEARANCE CLEAR

METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH 7.0 4.7 - 7.5

METHOD : DOUBLE INDICATOR PRINCIPLE

SPECIFIC GRAVITY 1.015 1.003 - 1.035

METHOD : PKA CHANGE OF PRETREATED POLYELECTROLYTES

PROTEIN NOT DETECTED NOT DETECTED

METHOD : PROTEIN- ERROR INDICATOR

GLUCOSE NOT DETECTED NOT DETECTED

METHOD : OXIDASE-PEROXIDASE REACTION

KETONES NOT DETECTED NOT DETECTED

METHOD : ACETOACETIC REACTION WITH NITROPRUSSIDE

BLOOD NOT DETECTED NOT DETECTED



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METHOD : PEROXIDASE-LIKE ACTIVITY OF HEMOGLOBIN

BILIRUBIN

NOT DETECTED

NOT DETECTED

METHOD : DIAZOTIZATION

UROBILINOGEN

NORMAL

NORMAL

METHOD : MODIFIED EHRlich REACTION

NITRITE

NOT DETECTED

NOT DETECTED

METHOD : CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE

NOT DETECTED

NOT DETECTED

METHOD : ESTERASE HYDROLYSIS ACTIVITY

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

METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED



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Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

THYROID PANEL, SERUM

T3	121.1	80.00 - 200.00	ng/dL
METHOD : ECLIA			
T4	6.64	5.10 - 14.10	µg/dL
METHOD : ECLIA			
TSH (ULTRASENSITIVE)	2.960	0.270 - 4.200	µIU/mL
METHOD : ECLIA			



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Email : wellness.eastdelhi@srl.in

PATIENT NAME : SHUBHAM ATRI

PATIENT ID : SHUBM20089128

ACCESSION NO : 0028WB00033 AGE : 31 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 11/02/2023 09:06

REPORTED : 13/02/2023 12:27

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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. Guidelines of the American Thyroid association during 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, STOOL

COLOUR

BROWN

METHOD : GUAIAC METHOD

CONSISTENCY

SEMI FORMED

METHOD : MANUAL

MUCUS

NOT DETECTED

NOT DETECTED



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METHOD : MANUAL				
VISIBLE BLOOD		ABSENT	ABSENT	
METHOD : MANUAL				
ADULT PARASITE		NOT DETECTED		
METHOD : CONCENTRATION AND MICROSCOPY				
CHEMICAL EXAMINATION,STOOL				
STOOL PH		6.5		
MICROSCOPIC EXAMINATION,STOOL				
PUS CELLS		0-1		/hpf
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : CONCENTRATION AND MICROSCOPY				
CYSTS		NOT DETECTED	NOT DETECTED	
METHOD : CONCENTRATION AND MICROSCOPY				
OVA		NOT DETECTED		
METHOD : CONCENTRATION AND MICROSCOPY				
LARVAE		NOT DETECTED	NOT DETECTED	
METHOD : CONCENTRATION AND MICROSCOPY				
TROPHOZOITES		NOT DETECTED	NOT DETECTED	
METHOD : CONCENTRATION AND MICROSCOPY				
FAT		ABSENT		
VEGETABLE CELLS		ABSENT		
CHARCOT LEYDEN CRYSTALS		ABSENT		
CONCENTRATION METHOD		OVA OR CYSTS NOT SEEN		



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Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc. The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days. Stool specimens for parasitic examination should be collected before initiation of anti-diarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects & reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

- Stool Culture**:- This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT)**: This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL**: In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test, (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
- Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomiting & abdominal cramps. Adults are also affected. It is highly contagious in nature.



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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE O

METHOD : COLUMN AGGLUTINATION TECHNOLOGY

RH TYPE POSITIVE

METHOD : COLUMN AGGLUTINATION TECHNOLOGY

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

NORMAL

TMT OR ECHO

TMT OR ECHO TMT DONE - NORMAL

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY HTN SINCE 10 DAYS
RELEVANT PAST HISTORY COVID POSITIVE ON 2021 AND 2022
RELEVANT PERSONAL HISTORY MARRIED ONE CHILD VEG
RELEVANT FAMILY HISTORY HIGH BLOOD PRESSUREFATHER AND
CANCER MOTHER
OCCUPATIONAL HISTORY JOB
HISTORY OF MEDICATIONS NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.75	mts
WEIGHT IN KGS.	88.6	Kgs
BMI	29	

BMI & Weight Status as follows: kg/sqmts
Below 18.5: Underweight
18.5 - 24.9: Normal
25.0 - 29.9: Overweight
30.0 and Above: Obese

GENERAL EXAMINATION



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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		
TEMPERATURE		NORMAL		
PULSE		107/MINUTE, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE		NORMAL		
CARDIOVASCULAR SYSTEM				
BP		136/92		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		S1, S2 HEARD NORMALLY		
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		
CENTRAL NERVOUS SYSTEM				



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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 WITH GLASSES	NORMAL
DISTANT VISION LEFT EYE WITH GLASSES	NORMAL
NEAR VISION RIGHT EYE WITH GLASSES	NORMAL
NEAR VISION LEFT EYE WITH GLASSES	NORMAL
COLOUR VISION	NORMAL

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL	NORMAL
TYMPANIC MEMBRANE	NORMAL
NOSE	NO ABNORMALITY DETECTED
SINUSES	CLEAR
THROAT	NO ABNORMALITY DETECTED
TONSILS	NOT ENLARGED

SUMMARY

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
RELEVANT LAB INVESTIGATIONS	WITHIN NORMAL LIMITS
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED
REMARKS / RECOMMENDATIONS	"NO ABNORMALITY FOUND OUT OF THE DIAGNOSTIC PACKAGE REQUESTED. GENERAL PHYSICAL EXAMINATION IS NORMAL."



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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.)

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, Vasculitides, 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: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs (Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis, (Sickle Cells, 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 so that 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, sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

NOTE:

Hypoglycemia is defined as a glucose of < 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 Glycosuria, 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 patient's metabolic control has remained continuously within the target range.



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

HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.

IV. Interference of hemoglobinopathies in HbA1c estimation is seen in

- Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
- Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- HbF > 25% on alternate platform (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 Glycosuria, 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 result 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 are 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



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Patient Ref. No. 28000001079636



CLIENT CODE : C000138361

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
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 CIN - U74899PB1995PLC045956
 Email : wellness.eastdelhi@srl.in

PATIENT NAME : SHUBHAM ATRI

PATIENT ID : SHUBM20089128

ACCESSION NO : 0028WB00033 **AGE :** 31 Years **SEX :** Male

ABHA NO :

DRAWN : **RECEIVED :** 11/02/2023 09:06

REPORTED : 13/02/2023 12:27

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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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.
 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.

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



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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

HEPATOMEGALY WITH FATTY CHANGE LIVER

****End Of Report****Please visit www.srlworld.com for related Test Information for this accession**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.

SRL Limited

Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062



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