

Dr. Vinay Chopra
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NAME	: Mrs. VANDANA MALHOTRA	PATIENT ID	: 1574355
AGE/ GENDER	: 47 YRS/FEMALE	REG. NO./LAB NO.	: 012408080023
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 08/Aug/2024 10:02 AM
REFERRED BY	:	COLLECTION DATE	: 08/Aug/2024 10:23AM
BARCODE NO.	: 01514697	REPORTING DATE	: 08/Aug/2024 10:55AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES


HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	9.3 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	3.94	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	30.7 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	77.8 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	23.6 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	30.3 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14.4	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	41.7	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	19.75	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	28.43	RATIO	BETA THALASSEMIA TRAIT: < = 65.0 IRON DEFICIENCY ANEMIA: > 65.0


WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	10790	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY</i>	NIL	%	< 10 %

DIFFERENTIAL LEUCOCYTE COUNT (DLC)




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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	63	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	28	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	6798	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	3021	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	432	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	540	/cmm	80 - 880
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	656000 ^H	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.6 ^H	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	9	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	134000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	20.4	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.8	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



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Test Name	Value	Unit	Biological Reference interval
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			
GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	7.5 ^H	%	4.0 - 6.4
ESTIMATED AVERAGE PLASMA GLUCOSE <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	168.55 ^H	mg/dL	60.00 - 140.00

INTERPRETATION:

AS PER AMERICAN DIABETES ASSOCIATION (ADA):		
REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (HBA1C) in %	
Non diabetic Adults >= 18 years	<5.7	
At Risk (Prediabetes)	5.7 – 6.4	
Diagnosing Diabetes	>= 6.5	
Age > 19 Years		
Therapeutic goals for glycemic control	Goals of Therapy:	< 7.0
	Actions Suggested:	>8.0
Age < 19 Years		
	Goal of therapy:	<7.5

- COMMENTS:**
- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
 - Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
 - Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0% may not be appropriate.
 - High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
 - Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
 - HbA1c results from patients with HbSS, HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term glycemic control.
 - Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.



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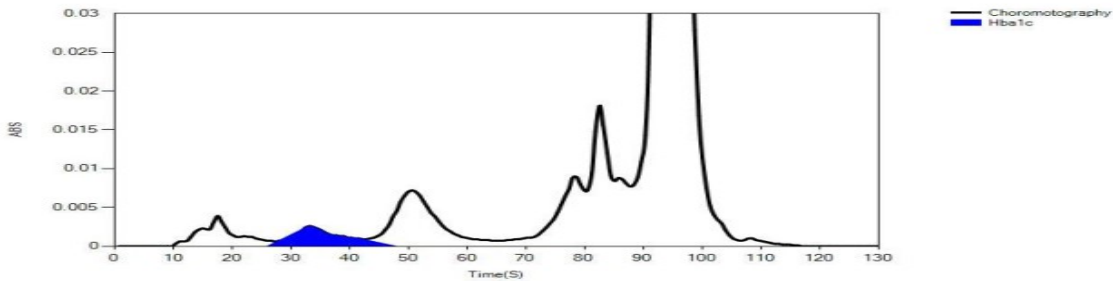
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Test Name	Value	Unit	Biological Reference interval
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LIFOTRONIC Graph Report

Name :	Case :	Patient Type :	Test Date : 08/08/2024 12:47:53
Age :	Department :	Sample Type : Whole Blood EDTA	Sample Id : 01514697
Gender :			Total Area : 9683

Peak Name	Retention Time(s)	Absorbance	Area	Result (Area %)
HbA0	69	2810	8624	86.6
HbA1c	37	72	750	7.5
La1c	28	12	134	1.3
HbF	21	7	10	0.1
Hba1b	12	39	96	1.0
Hba1a	10	23	69	0.7




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) <i>by MODIFIED WESTERGREN AUTOMATED METHOD</i>	81 ^H	mm/1st hr	0 - 20
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INTERPRETATION:

- ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
- An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
- This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

CONDITION WITH LOW ESR

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

NOTE:

- ESR and C - reactive protein (C-RP) are both markers of inflammation.
- Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
- CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
- If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
- Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
- Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it



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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	80.17	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose level below 100 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
3. A fasting plasma glucose level of above 125 mg/dl is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients. A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.



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Test Name	Value	Unit	Biological Reference interval
LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	127.69	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	104.2	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	32.18	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	74.67	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	95.51	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	20.84	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	359.58	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.97	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.32	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0



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TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.24	RATIO	3.00 - 5.00

INTERPRETATION:

- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
- As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
- Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
- Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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SGOT/SGPT PROFILE

SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	17.2	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	21.8	U/L	0.00 - 49.00
SGOT/SGPT RATIO <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.79		

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Reference Range.
USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:-

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTASIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)


DECREASED:-


- Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
- Extra Hepatic cholestasis: 0.8 (normal or slightly decreased).

PROGNOSTIC SIGNIFICANCE:-

NORMAL	< 0.65
GOOD PROGNOSTIC SIGN	0.3 - 0.6
POOR PROGNOSTIC SIGN	1.2 - 1.6




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Test Name	Value	Unit	Biological Reference interval
UREA			
UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	35.2	mg/dL	10.00 - 50.00

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CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
CREATININE			
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.11	mg/dL	0.40 - 1.20

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TEST PERFORMED AT: KOS DIAGNOSTIC LAB, AMBALA CANTT.

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 Chairman & Consultant Pathologist

Dr. Yugam Chopra
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 CEO & Consultant Pathologist

NAME	: Mrs. VANDANA MALHOTRA	PATIENT ID	: 1574355
AGE/ GENDER	: 47 YRS/FEMALE	REG. NO./LAB NO.	: 012408080023
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 08/Aug/2024 10:02 AM
REFERRED BY	:	COLLECTION DATE	: 08/Aug/2024 10:23AM
BARCODE NO.	: 01514697	REPORTING DATE	: 08/Aug/2024 11:36AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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ENDOCRINOLOGY

THYROID STIMULATING HORMONE (TSH)

THYROID STIMULATING HORMONE (TSH): SERUM 0.486 μ IU/mL 0.35 - 5.50
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

AGE	REFERENCE RANGE (μ IU/mL)
0 – 5 DAYS	0.70 – 15.20
6 Days – 2 Months	0.70 – 11.00
3 – 11 Months	0.70 – 8.40
1 – 5 Years	0.70 – 7.00
6 – 10 Years	0.60 – 5.50
11 - 15	0.50 – 5.50
> 20 Years (Adults)	0.27 – 5.50
PREGNANCY	
1st Trimester	0.10 - 3.00
2nd Trimester	0.20 - 3.00
3rd Trimester	0.30 - 4.10

NOTE:- TSH levels are subjected to circadian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50 %. Hence time of the day has influence on the measured serum TSH concentration.

USE:- TSH controls biosynthesis and release of thyroid hormones T4 & T3. It is a sensitive measure of thyroid function, especially useful in early or subclinical hypothyroidism, before the patient develops any clinical findings or goitre or any other thyroid function abnormality.

INCREASED LEVELS:

- 1.Primary or untreated hypothyroidism, may vary from 3 times to more than 100 times normal depending on degree of hypofunction.
- 2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3.Hashimotos thyroiditis.
- 4.DRUGS: Amphetamines, Iodine containing agents and dopamine antagonist.
- 5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge.

DECREASED LEVELS:

- 1.Toxic multi-nodular goitre & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.



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7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.


8.Pregnancy: 1st and 2nd Trimester

LIMITATIONS:

- 1.TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.
- 2.Autoimmune disorders may produce spurious results.

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IMMUNOPATHOLOGY/SEROLOGY

C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE:	25.77 ^H	mg/L	0.0 - 6.0
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SERUM
by NEPHLOMETRY

INTERPRETATION:

1. C-reactive protein (CRP) is one of the most sensitive acute-phase reactants for inflammation.
2. CRP levels can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgery, or neoplastic proliferation.
3. CRP levels (Quantitative) has been used to assess activity of inflammatory disease, to detect infections after surgery, to detect transplant rejection, and to monitor these inflammatory processes.
4. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.,
5. Elevated values are consistent with an acute inflammatory process.

- NOTE:**
1. Elevated C-reactive protein (CRP) values are nonspecific and should not be interpreted without a complete clinical history.
 2. Oral contraceptives may increase CRP levels.



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KOS Diagnostic Lab
(A Unit of KOS Healthcare)



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Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
COLOUR	AMBER YELLOW		PALE YELLOW
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
TRANSPARANCY	CLEAR		CLEAR
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

CHEMICAL EXAMINATION

REACTION	ACIDIC		
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
PROTEIN	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SUGAR	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
pH	5.5		5.0 - 7.5
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BILIRUBIN	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
NITRITE	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.</i>			
UROBILINOGEN	NOT DETECTED	EU/dL	0.2 - 1.0
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
KETONE BODIES	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BLOOD	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

MICROSCOPIC EXAMINATION



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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	2-3	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	3-4	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

*** End Of Report ***

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