



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

☎ 0171-2532620, 8222896961 ✉ pkrajainhealthcare@gmail.com

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

NAME	: Mr. YAAD RAM	PATIENT ID	: 1675888
AGE/ GENDER	: 51 YRS/MALE	REG. NO./LAB NO.	: 122411190014
COLLECTED BY	:	REGISTRATION DATE	: 19/Nov/2024 11:00 AM
REFERRED BY	:	COLLECTION DATE	: 19/Nov/2024 11:10AM
BARCODE NO.	: 12505735	REPORTING DATE	: 19/Nov/2024 01:58PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

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>	12	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	4.89	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	36.9^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	75.5^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	24.6^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.6	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>	40.8	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	15.44	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	22.29	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>	7950	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	61	%	50 - 70
LYMPHOCYTES	29	%	20 - 40



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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
EOSINOPHILS	4	%	1 - 6
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
MONOCYTES	6	%	2 - 12
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
BASOPHILS	0	%	0 - 1
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT	4850	/cmm	2000 - 7500
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE LYMPHOCYTE COUNT	2306	/cmm	800 - 4900
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE EOSINOPHIL COUNT	318	/cmm	40 - 440
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE MONOCYTE COUNT	477	/cmm	80 - 880
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE BASOPHIL COUNT	0	/cmm	0 - 110
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT)	339000	/cmm	150000 - 450000
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELETCRIT (PCT)	0.31	%	0.10 - 0.36
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
MEAN PLATELET VOLUME (MPV)	9	fL	6.50 - 12.0
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELET LARGE CELL COUNT (P-LCC)	72000	/cmm	30000 - 90000
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELET LARGE CELL RATIO (P-LCR)	21.2	%	11.0 - 45.0
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELET DISTRIBUTION WIDTH (PDW)	15.3	%	15.0 - 17.0
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	30^H	mm/1st hr	0 - 20
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by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and autoimmune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. 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
3. 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:

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. 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 RANDOM (R)

GLUCOSE RANDOM (R): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	78.88	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A random plasma glucose level below 140 mg/dl is considered normal.
2. A random glucose level between 140 - 200 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 random glucose level of above 200 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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ELECTROLYTES PROFILE: SODIUM AND POTASSIUM

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	139.9	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	3.86	mmol/L	3.50 - 5.00

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and iadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical issuficiency .
7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushings syndrome
5. Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.

HYPOKALEMIA (LOW POTASSIUM LEVELS):-

1. Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3. Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1. Oliguria
2. Renal failure or Shock
3. Respiratory acidosis
4. Hemolysis of blood



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ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

THYROIDAL THYRONINE (T3): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	1.28	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	7.37	µg/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i> 3rd GENERATION, ULTRASENSITIVE	2.21	µIU/mL	0.35 - 5.50

INTERPRETATION:

TSH levels are subject 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 concentrations. TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4) and triiodothyronine (T3). Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

CLINICAL CONDITION	T3	T4	TSH
Primary Hypothyroidism:	Reduced	Reduced	Increased (Significantly)
Subclinical Hypothyroidism:	Normal or Low Normal	Normal or Low Normal	High
Primary Hyperthyroidism:	Increased	Increased	Reduced (at times undetectable)
Subclinical Hyperthyroidism:	Normal or High Normal	Normal or High Normal	Reduced

LIMITATIONS:-

- T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
- Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (e.g.: phenytoin , salicylates).
- Serum T4 levels in neonates and infants are higher than values in the normal adult , due to the increased concentration of TBG in neonate serum.
- TSH may be normal in central hypothyroidism , recent rapid correction of hyperthyroidism or hypothyroidism , pregnancy , phenytoin therapy.

TRIIODOTHYRONINE (T3)		THYROXINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	Refferance Range (ng/mL)	Age	Refferance Range (µg/dL)	Age	Reference Range (µIU/mL)
0 - 7 Days	0.20 - 2.65	0 - 7 Days	5.90 - 18.58	0 - 7 Days	2.43 - 24.3
7 Days - 3 Months	0.36 - 2.59	7 Days - 3 Months	6.39 - 17.66	7 Days - 3 Months	0.58 - 11.00
3 - 6 Months	0.51 - 2.52	3 - 6 Months	6.75 - 17.04	3 Days - 6 Months	0.70 - 8.40
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 - 16.16	6 - 12 Months	0.70 - 7.00




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1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80
11 - 19 Years	0.35 - 1.93	11 - 19 Years	4.87 - 13.20
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (μ IU/mL)			
	1st Trimester		0.10 - 2.50
	2nd Trimester		0.20 - 3.00
	3rd Trimester		0.30 - 4.10

INCREASED TSH LEVELS:

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

DECREASED TSH LEVELS:

- 1.Toxic multi-nodular goiter & 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.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
- 8.Pregnancy: 1st and 2nd Trimester




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IMMUNOPATHOLOGY/SEROLOGY

RHEUMATOID FACTOR (RA): QUANTITATIVE - SERUM

RHEUMATOID (RA) FACTOR QUANTITATIVE: SERUM by NEPHLOMETRY	1.16	IU/mL	NEGATIVE: < 18.0 BORDERLINE: 18.0 - 25.0 POSITIVE: > 25.0
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INTERPRETATION:-

RHEUMATOID FACTOR (RA):

- Rheumatoid factors (RF) are antibodies that are directed against the Fc fragment of IgG altered in its tertiary structure.
- Over 75% of patients with rheumatoid arthritis (RA) have an IgM antibody to IgG immunoglobulin. This autoantibody (RF) is diagnostically useful although it may not be etiologically related to RA.
- Inflammatory Markers such as ESR & C-Reactive protein (CRP) are normal in about 60 % of patients with positive RA.
- The titer of RF correlates poorly with disease activity, but those patients with high titers tend to have more severe disease course.
- The test is useful for diagnosis and prognosis of rheumatoid arthritis.

RHEUMATOID ARTHRITIS:

- Rheumatoid Arthritis is a systemic autoimmune disease that is multi-functional in origin and is characterized by chronic inflammation of the membrane lining (synovium) joints which leads to progressive joint destruction and in most cases to disability and reduction of quality life.
- The disease spreads from small to large joints, with greatest damage in early phase.
- The diagnosis of RA is primarily based on clinical, radiological & immunological features. The most frequent serological test is the measurement of RA factor.

CAUTION (FALSE POSTIVE):-

- RA factor is not specific for Rheumatoid arthritis, as it is often present in healthy individuals with other autoimmune diseases and chronic infections.
- Non rheumatoid and rheumatoid arthritis (RA) populations are not clearly separate with regard to the presence of rheumatoid factor (RF) (15% of RA patients have a nonreactive titer and 8% of nonrheumatoid patients have a positive titer).
- Patients with various nonrheumatoid diseases, characterized by chronic inflammation may have positive tests for RF. These diseases include systemic lupus erythematosus, polymyositis, tuberculosis, syphilis, viral hepatitis, infectious mononucleosis, and influenza.
- Anti-CCP have been discovered in joints of patients with RA, but not in other form of joint disease. Anti-CCP2 is HIGHLY SENSITIVE (71%) & more specific (98%) than RA factor.
- Upto 30 % of patients with Seronegative Rheumatoid arthritis also show Anti-CCP antibodies.
- The positive predictive value of Anti-CCP antibodies for Rheumatoid Arthritis is far greater than Rheumatoid factor.



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VITAMINS

VITAMIN B12/COBALAMIN

VITAMIN B12/COBALAMIN: SERUM 574.01 pg/mL 200 - 940
 by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:-

INCREASED VITAMIN B12	DECREASED VITAMIN B12
1.Ingestion of Vitamin C	1.Pregnancy
2.Ingestion of Estrogen	2.DRUGS:Aspirin, Anti-convulsants, Colchicine
3.Ingestion of Vitamin A	3.Ethanol lgestion
4.Hepatocellular injury	4. Contraceptive Harmones
5.Myeloproliferative disorder	5.Haemodialysis
6.Uremia	6. Multiple Myeloma

- Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function.
 - In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption.
 - The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted.
 - Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases).
 - Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia.
 - Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.
 - Follow-up testing for antibodies to intrinsic factor (IF) is recommended to identify this potential cause of vitamin B12 malabsorption.
- NOTE:**A normal serum concentration of vitamin B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for vitamin B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum vitamin B12 concentrations are normal.




 DR.VINAY CHOPRA
 CONSULTANT PATHOLOGIST
 MBBS, MD (PATHOLOGY & MICROBIOLOGY)


 DR.YUGAM CHOPRA
 CONSULTANT PATHOLOGIST
 MBBS, MD (PATHOLOGY)





PKR JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

☎ 0171-2532620, 8222896961 ✉ pkrjainhealthcare@gmail.com

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

NAME	: Mr. YAAD RAM	PATIENT ID	: 1675888
AGE/ GENDER	: 51 YRS/MALE	REG. NO./LAB NO.	: 122411190014
COLLECTED BY	:	REGISTRATION DATE	: 19/Nov/2024 11:00 AM
REFERRED BY	:	COLLECTION DATE	: 19/Nov/2024 11:10AM
BARCODE NO.	: 12505735	REPORTING DATE	: 19/Nov/2024 01:58PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	25	ml	
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
COLOUR	PALE YELLOW		PALE YELLOW
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
TRANSPARANCY	HAZY		CLEAR
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SPECIFIC GRAVITY	1.02		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	6		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

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

*** End Of Report ***



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