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COMPLETE BLOOD COUNT (CBC with E.S.R).

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
HEMOGLOBIN, Blood(SLS Hemoglobin)	15.2	13.00 - 17.00	g/dl
PACKED CELL VOLUME, Blood(Impedence)	45.2	40 - 50	%
TLC, Blood (Flow cytometry)	5000.00	4000 - 11000	/cumm
D.L.C., Blood (Flow Cytometry)			
POLYMORPHS	49.0	44.00 - 68.00	%
LYMPHOCYTES	39.00	25.00 - 44.00	%
EOSINOPHILS	**5.0**	0.00 - 4.00	%
MONOCYTES	7.00	0.00 - 7.00	%
ABSOLUTE NEUTROPHIL COUNT(Blood, Calculated).	2450.00	2000 - 7000	/Cu mm
ABSOLUTE EOSINOPHIL COUNT BLOOD, (Calculated)	250.00	20 - 500	/Cu mm
PLATELET COUNT, Blood (Impedence)	201.00	150 - 410	1000/Cumm
E.S.R, Blood(Capillary Photometry)	2.00	0.00 - 15.00	1st hour
R B C COUNT, Blood (Impedence)	4.98	4.5 - 5.5	10^12/L
MCV, Blood(Calculated)	90.76	83 - 101	fl
MCH, Blood(Calculated)	30.52	27.00 - 32.60	Pg
MCHC, Blood(Calculated)	33.63	31.50 - 34.50	gm/dl
RDW, Blood (Calculated)	12.7	11.6 - 14.0	%

COMMENTS ON PERIPHERAL SMEAR : (Microscopy, Leishman stain) The red blood cells are normocytic and normochromic. The white cells are normal. The platelets are adequate.

*Test performed by SYSMEX XN-550.

Absolute Neutrophil Count (ANC) <1000 - Markedly increased susceptibility of infectious diseases.

- Absolute Neutrophil Count (ANC) <500 control of endogenous microbial flora impaired.
- Absolute Neutrophil Count (ANC) <200 absent inflammatory processes.

Comments:

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REPORT

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years	MALE	
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:		
Ref. Doctor	: SELF	**Hospital / NH**	: NA				

Investigation	Result	Biological Reference Interval	Units
FASTING GLUCOSE, Plasma(Hexokinase)	90.8	60 - 100	mg/dl

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HbA1c

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Units
GLYCOSYLATED HEMOGLOBIN (HbA1c) Immunoturbidimetry	5.1	%

REFERENCE RANGE:

4.00 - 5.60 % Normal
5.70 - 6.40 % Prediabetes (The values should be co-related with Glucose levels)
6.10 - 7.00 % HbA1C indicates very good control in diabetes
7.10 - 8.00 % HbA1C indicates adequate control in diabetes
8.10 - 9.00 % HbA1C indicates suboptimal control in diabetes
>9.00% HbA1C indicates poor control in diabetes

HbA1c (%)	Average Glucose mg/dl
5	97
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Note :

An estimated average glucose (eAG) can be calculated from the HbA1c values. The A1c test is also used to monitor the glucose control of diabetics over time. This helps to minimize the complications caused by chronically elevated glucose levels, such as progressive damage to kidneys, eyes, cardiovascular system, and nerves.

The A1c test, however, should not be used for screening for cystic fibrosis-related diabetes, people who have had recent severe bleeding or blood transfusions, those with chronic kidney or liver disease, or people with blood disorders such as iron-deficiency anemia, vitamin B12 deficiency anemia, and some Hemoglobin variants (e.g., patients with sickle cell disease or Thalassemia).

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LIPID PROFILE

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
CHOLESTROL, SERUM (Enz. Colorimetry)	**235.3**	80.00 - 200.00	mg/dl
HDL CHOLESTEROL (Enz.Colorimetry)	55.00	30.00 - 60.00	mg/dl
TRIGLYCERIDES, SERUM (Enz.Colorimetry)	149.13	40.00 - 150.00	mg/dl
VLDL CHOLESTEROL (Calculated)	29.83	24.00 - 45.00	mg/dl
LDL CHOLESTEROL (Enz.Colorimetry)	**150.47**	30.00 - 100.00	mg/dl
LDL / HDL RATIO (Calculated)	2.74	0.00 - 3.00	
CHOLESTEROL / HDL RATIO(Calculated)	**4.28**	0.00 - 4.00	

INTERPRETATION :-
Desirable : Less than 200 mg/dl
Borderline High Risk : 200 to 239 mg/dl
High Risk : 240 mg/dl and over, on repeated values
Optimal Level for Cardiac Patients : Less than 200 mg/dl
TRIGLYCERIDES REFERECE RANGE
> Normal - Less than 150 mg/dL,
> Borderline high - 150 to 199 mg/dL
> High - 200 to 499 mg/dL
> Very high - 500 mg/dL or above
HDL-C : High HDL has generally been found to be protective, decreasing the risk of coronary Artery disease (CAD) in most people. However, some recent studies have shown that in some people with high HDL, the HDL is not protective and may, in fact result in higher risk for CAD than in people with normal HDL levels. In one study it was shown that people with CAD and high HDL had underlying genetic anomalies in enzymes important in lipid turnover. Another study showed that high levels of abnormally large HDL particles were associated with increased risk of CAD. Factors that elevate HDL concentrations include chronic alcoholism, treatment with oral estrogen replacement therapy, extensive aerobic exercise, and treatment with niacin, statins, or fibrates. Smoking reduces levels of HDL cholesterol, while quitting smoking leads to a rise in the plasma HDL level.
LDL Reference Range : Levels in terms of risk for coronary heart disease :
Adult levels:
Optimal <100 mg/dL
Near Optimal/ above optimal 100 -129 mg/dL
Borderline high 130 - 159 mg/dL
High 160 - 189 mg/dL
Very High >=190 mg/dL
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Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years	MALE	
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:		
Ref. Doctor	: SELF	**Hospital / NH**	: NA				

Investigation	Result	Biological Reference Interval	Units
IRON, Serum(Ferrozine)	145.5	33.00 - 193.00	ug/dl
UIBC Serum(Ferrozine)	182.9	125.00 - 345.00	ug/dl
TIBC.(Calculated)	328.40	250.00 - 450.00	ug/dl

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L.F.T WITH G.G.T.P

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
BILIRUBIN (TOTAL), Serum(Diazo)	0.77	0.00 - 1.20	mg/dl
BILIRUBIN (DIRECT), Serum(Diazo)	0.26	0 - 0.30	mg/dl
BILIRUBIN (INDIRECT), Serum(Calculated)	0.51	0.00 - 0.70	mg/dl
TOTAL PROTEINS Serum(Biuret)	7.3	6.40 - 8.30	gms/dl
ALBUMIN, Serum(BCG)	4.8	3.50 - 5.20	gms/dl
GLOBULIN (Calculated)	2.50	2.00 - 3.50	gms/dl
A:G RATIO (Calculated)	1.92	1.00 - 2.00	
ALKALINE PHOSPHATASE,Serum(Colorimetry)	68.0	40.00 - 130.00	U/L
SGOT, Serum(IFCC)	24.3	1.00 - 40.00	U/l
SGPT, Serum(IFCC)	34.4	2.00 - 41.00	U/l
GGTP, Serum(Enz.Colorimetry)	35.2	8.00 - 61.00	U/L

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REPORT

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
FERRITIN, Serum,(CLIA)	160.40	22.00 - 322.00	ng/ml

Summary and Explanation of the Test:

Ferritin is a compound composed of iron molecules bound to apoferritin, a protein shell. Stored iron represents about 25% of total iron in the body, and most of this iron is stored as ferritin.Ferritin is found in many body cells, but especially those in the liver, spleen, bone marrow, and in reticuloendothelial cells.Ferritin plays a significant role in the absorption, storage, and release of iron. As the storage form of iron, ferritin remains in the body tissues until it is needed for erythropoiesis. When needed, the iron molecules are released from the apoferritin shell and bind to transferrin, the circulating plasma protein that transports iron to the erythropoietic cells.Although dietary iron is poorly absorbed, the body conserves its iron stores carefully, reabsorbing most of the iron released from the breakdown of red blood cells. As a result, the body normally loses only 1 to 2 mg of iron per day, which is generally restored by the iron absorbed in the small intestine from dietary sources.Ferritin is found in serum in low concentrations and is directly proportional to the body~s iron stores.Serum ferritin concentration, when analyzed with other factors such as serum iron, iron-binding capacity, and tissue iron stores, is valuable in the diagnosis of iron-deficiency anemias, anemias of chronic infection, and conditions such as thalassemia and hemochromatosis that are associated with iron overload. Measurement of serum ferritin is particularly valuable in distinguishing iron-deficiency anemias caused by low iron stores from those resulting from inadequate iron utilization.

Limitations:

Serum ferritin values are elevated in the presence of the following conditions and do not reflect actual body iron stores:

- inflammation
- significant tissue destruction
- liver disease
- malignancies such as acute leukemia and Hodgkin,s disease
- therapy with iron supplements

Some estimated ferritin levels is various pathophysiological conditions

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Category	Range(ng/mL)	Category	Range(ng/mL)
Iron Deficiency	0.68 - 34.5	Other Anemias	13.0 - 1390.8
Iron Overload	334.6 - 8573.0	Renal Dialysis	31.3 - 1321.2
Chronic Liver Disease	7.9 - 12,826.0		

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays.Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed.

Comments:

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KIDNEY FUNCTION TEST (KFT)

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
UREA Serum(Urease)	23.61	12.00 - 45.00	mg/dl
UREA NITROGEN(Calculated)	11.03	6.00 - 20.00	mg/dl
CREATININE SERUM(Jaffe)	0.85	0.70 - 1.20	mg/dl
URIC ACID, Serum(Colorimetry)	6.8	3.40 - 7.00	mg/dl
CALCIUM, Serum(BAPTA)	9.93	8.60 - 10.00	mg/dl
PHOSPHATE, Serum(Phosphomolybdate)	3.4	2.50 - 4.80	mg/dl
SODIUM, Serum(ISE Indirect)	142.2	130.00 - 149.00	meq/L
POTASSIUM, Serum(ISE Indirect)	4.61	3.50 - 5.00	meq/L
CHLORIDE, Serum(ISE Indirect)	102.9	97.0 - 107.0	meq/L

Comments:

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REPORT

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:19	**Age/Sex**	: 36 Years	MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:	
Ref. Doctor	: SELF	**Hospital / NH**	: NA			

Investigation	Result	Biological Reference Interval	Units
TRANSFEERRIN.	277.87	200.00 - 360.00	mg/dl
Comments:			
TRANSFERRIN SATURATION	44.30	16.00 - 45.00	%
Comments:			

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CARCINOEMBRYONIC ANTIGEN

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:19	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
CEA, Serum,(CLIA)	1.74	0.00 - 10.00	ng/ml

Summary and Explanation of the Test:

Carcinoembryonic antigen is a glycoprotein normally found in embryonic endo epithelium. CEA belongs to a group of tumor markers referred to as oncofetal proteins. Increased serum CEA levels have been detected in persons with primary colorectal cancer and in patients with other malignancies including gastrointestinal tract, breast, lung, ovarian,prostatic, liver, and pancreatic cancers.Elevated serum CEA have also been detected in patients with nonmalignant disease, especially patients who are older or who are smokers.CEA levels are not useful in screening the general population for undetected cancers. However, CEA levels provide important information about patient prognosis, recurrence of tumors after surgical removal, and effectiveness of therapy.Serial CEA levels are useful in monitoring the course of disease. CEA levels generally fall to normal or near normal levels within 1 to 4 months after surgical removal of cancerous tissue.A rise in CEA levels may be the first indication of recurrence, and may precede physical signs and symptoms.Serial CEA levels are also useful in assessing the effectiveness of chemotherapy or radiation treatment. A sustained rise in CEA levels can indicate ineffective therapy or possible metastasis.CEA is a useful tool for monitoring and managing cancer therapy, and provides the clinician with additional information about patient prognosis.In a group of 500 healthy persons, 95% of the serum CEA values were found to be between 0 and 4.6 ng/ml. The upper limit was 10.0 ng/ml.

Limitations:

NOTE: Do not interpret levels of CEA as absolute evidence of the presence or the absence of malignant disease. Measurements of CEA should always be used in conjunction with other diagnostic procedures, including information from the patient~s clinical evaluation.The concentration of CEA in a given specimen determined with assays from different manufacturers can vary due to differences in assay methods, calibration, and reagent specificity.CEA determined with different manufacturers~ assays will vary depending on the method of standardization and antibody specificity.Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays.Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed.

Comments:

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THYROID PROFILE.

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
FT3, Serum,(CLIA)	5.25	3.10 - 6.80	pmol/L
FREE T4, Serum,(CLIA)	17.41	12.00 - 22.00	pmol/l
TSH, (ULTRASENSITIVE) Serum,(CLIA)	3.35	0.27 - 4.20	uIU/ml

* PHYSIOLOGICAL ALTERATIONS IN THYROID VALUES

FT3

Adults	3.1 - 6.8
Children & adolescence	
4-30 days	2.6 -8.3
2-12 mths	2.4 -9.8
2-6 years	2.9 -9.5
7-11 years	2.5 -9.2
12-19 years	3.1 -9.2

Adults	
TSH	0.27 - 4.20 uIU/ml
Children	TSH (Ranges uIU/ml)
Midgestation Fetus	0.70 - 11.00
LBW cord serum	1.30 - 20.00
Term Infants	1.30 - 19.00
3 days	1.10 - 17.00
10 weeks	0.60 - 10.00
14 months	0.40 - 7.00
5 years	0.40 - 6.00

Pregnancy	Units	First Trimester	Second Timester	Third Trimester
Free T3	pmol/L	3.00 - 5.70	2.80 - 4.20	2.40 - 4.10
Free T4	pmol/L	11.10 - 24.10	8.20 - 24.70	8.20 - 24.70
TSH	uIU/mL	0.20 - 3.50	0.20 - 3.50	0.20 - 3.50

Comments:

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ISO 9001:2015 URS UKAS MANAGEMENT SYSTEMS 043-A

PSA

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:19	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Units
PSA, Serum,(CLIA)	0.9	ng/ml

Age(Years)	Range
< 40	0 - 1.4
40-59	0 - 2.0
50-60	0 - 3.1
60-70	0 - 4.1
> 70	0 - 4.4

Summary and Explanation of the Test

Prostate-specific antigen (PSA) is a single-chain glycoprotein normally found in the acini and ducts of the prostate gland. PSA is detected in the serum of males with normal, benign hypertrophic, and malignant prostate tissue. PSA is not detected in the serum of males without prostate tissue (because of radical prostatectomy or cystoprostatectomy) or in the serum of most females. The fact that PSA is unique to prostate tissue makes it a suitable marker for monitoring men with cancer of the prostate. PSA is also useful for determining possible recurrence after therapy when used in conjunction with other diagnostic indices. Measurement of serum PSA levels is not recommended as a screening procedure for the diagnosis of cancer because elevated PSA levels also are observed in patients with benign prostatic hypertrophy. However, studies suggest that the measurement of PSA in conjunction with digital rectal examination (DRE) and ultrasound provide a better method of detecting prostate cancer than DRE alone. PSA levels increase in men with cancer of the prostate, and after radical prostatectomy PSA levels routinely fall to the undetectable range. If prostatic tissue remains after surgery or metastasis has occurred, PSA appears to be useful in detecting residual and early recurrence of tumor.Therefore, serial PSA levels can help determine the success of prostatectomy, and the need for further treatment, such as radiation, endocrine or chemotherapy, and in the monitoring of the effectiveness of therapy.

Limitations

Do not interpret levels of PSA as absolute evidence of the presence or the absence of malignant disease. Before treatment, patients with confirmed prostate carcinoma frequently have levels of PSA within the range observed in healthy individuals. Elevated levels of PSA can be observed in patients with nonmalignant diseases. Measurements of PSA should always be used in conjunction with other diagnostic procedures, including information from the patient~s clinical evaluation.

The concentration of total PSA in a given specimen determined with assays from different manufacturers can vary due to differences in assay methods, calibration, and reagent specificity.

Total PSA determined with different manufacturers~ assays will vary depending on the method of standardization and antibody specificity.

WARNING: Do not predict disease recurrence solely on serial PSA values.

Comments:

*** END OF REPORT ***

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ISO 9001:2015 UKAS MANAGEMENT SYSTEMS 043-A

TESTOSTERONE

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:19	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
TESTOSTERONE, Serum,(CLIA)	**8.2**	1.75 - 7.81	ng/ml

Summary and Explanation of the Test:

Testosterone is the major androgen in males and is controlled by luteinizing hormone which released from the anterior pituitary exerting the primary control on testosterone production and acting directly on the Leydig cells in the testes. Testosterone stimulates adult maturation of external genitalia and secondary sex organs, and the growth of beard, axillary and pubic hair. In addition, testosterone has anabolic effects leading to increased linear growth, nitrogen retention, and muscular development. Clinical evaluation of serum testosterone, along with serum LH, assists in evaluation of hypogonadal males. Major causes of lowered testosterone in males include hypogonadotropic hypogonadism, testicular failure, hyperprolactinemia, hypopituitarism, some types of liver and kidney diseases, and critical illness. Testosterone levels are much lower in females compared to males. The major sources of testosterone in females are the ovaries, the adrenal glands, and the peripheral conversion of precursors, specifically the conversion of androstenedione to testosterone. In females, the normal levels of androgens may provide substrate for estrogen production. Increased serum testosterone levels in females may be indicative of polycystic ovary syndrome and adrenal hyperplasia, among other conditions. The clinical manifestations of excess testosterone include infertility, hirsutism, amenorrhea, and obesity.

Limitations:

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays.Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed.

Comments:

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ISO 9001-2015 043-A

VITAMIN B12

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Units
VITAMIN B12 (CLIA)	717.1	pg/ml

Category Range (pg/mL)	Range (pg/mL)
Normal	180-914
Indeterminate	145-180
Deficient	</=145.00

Summary and Explanation of the Test

Vitamin B12, or cyanocobalamin, is a complex corrinoid compound containing four pyrrole rings that surround a single cobalt atom. Humans obtain vitamin B12 exclusively from animal dietary sources, such as meat, eggs, and milk. Vitamin B12 requires intrinsic factor, a protein secreted by the parietal cells in the gastric mucosa, for absorption. Vitamin B12 and intrinsic factor form a complex that attaches to receptors in the ileal mucosa, where proteins known as trans-cobalamins transport the vitamin B12 from the mucosal cells to the blood and tissues. Most vitamin B12 is stored in the liver as well as in the bone marrow and other tissues. Vitamin B12 and folate are critical to normal DNA synthesis, which in turn affects erythrocyte maturation. Vitamin B12 is also necessary for myelin sheath formation and maintenance. The body uses its B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver so that very little is excreted.

Clinical and laboratory findings for B12 deficiency include neurological abnormalities, decreased serum B12 levels, and increased excretion of methylmalonic acid. The impaired DNA synthesis associated with vitamin B12 deficiency causes macrocytic anemias. These anemias are characterized by abnormal maturation of erythrocyte precursors in the bone marrow, which results in the presence of megaloblasts and in decreased erythrocyte survival. Pernicious anemia is a macrocytic anemia caused by vitamin B12 deficiency that is due to lack of intrinsic factor. Low vitamin B12 intake, gastrectomy, diseases of the small intestine, malabsorption, and trans-cobalamin deficiency can also cause vitamin B12 deficiency.

Evaluation of vitamin B12 deficiency should not depend on results from a single test. Complete evaluation should include other deficiency function tests and results from a physician~s clinical evaluation.

Limitations

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* kindly Correlate Clinically

Comments:

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VITAMIN D, 25 - HYDROXY

Reference No.	: 190943533	**Reg. Date**	: 06-Sep-2019 12:21	**Age/Sex**	: 36 Years MALE
Patient	: MR. AMAR SARIN	**Print Date**	: 06-Sep-2019	**Delivery**	:
Ref. Doctor	: SELF	**Hospital / NH**	: NA		

Investigation	Result	Biological Reference Interval	Units
VITAMIN D, 25-HYDROXY, Serum,(CLIA)	84.0	75.00 - 250.00	nmol/L

Comments:

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