



LABORATORY REPORT

Name : Mrs. KRISHNA MILAP DESAI	Sex/Age : Female / 50 Years	Case ID : 50603602392
Ref. By : Dr. Ashok U. Prajapati M.D.	Dis. At :	Pt. ID : 6055383
Bill. Loc. :		Pt. Loc. :
Reg Date and Time : 04-Jun-2025 11:28	Sample Type :	Mobile No. : 9913120494
Sample Date and Time :	Sample Coll. By : NAL	Ref Id1 :
Report Date and Time :	Acc. Remarks :	Ref Id2 :

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Glyco Hemoglobin (HbA1c)			
HbA1C	6.00	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes As per ADA 2021 Guidelines
Haemogram (CBC)			
Haemoglobin	9.2	g/dL	12.00 - 15.00
PCV(Calc)	30.3	%	36.00 - 46.00
MCV (RBC histogram)	78.9	fL	83.00 - 101.00
MCH (Calc)	24.0	pg	27.00 - 32.00
MCHC (Calc)	30.4	g/dL	31.50 - 34.50
PDW	7.6	%	8 - 13
RBC Morphology	Hypochromasia(+) Microcytosis(+)		
Lipid Profile			
HDL Cholesterol	35.0	mg/dL	40 - 60
Chol/HDL	4.26		0 - 4.1
Urine Examination			
Leucocyte	3-4	/HPF	Nil
Calcium	8.30	mg/dL	8.4 - 10.2
VITAMIN B - 12	178.0	pg/mL	211 - 911

Abnormal Result(s) Summary End

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Page 1 of 15

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Sample Date and Time : 04-Jun-2025 11:21	Sample Coll. By : NAL	Ref Id1 :
Report Date and Time : 04-Jun-2025 12:32	Acc. Remarks :	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
HAEMOGRAM REPORT				
<u>HB AND INDICES</u>				
Haemoglobin	L 9.2	g/dL	12.00 - 15.00	
RBC (Electrical Impedance)	3.84	$\times 10^6$ / μ L	3.80 - 4.80	
PCV(Calc)	L 30.3	%	36.00 - 46.00	
MCV (RBC histogram)	L 78.9	fL	83.00 - 101.00	
MCH (Calc)	L 24.0	pg	27.00 - 32.00	
MCHC (Calc)	L 30.4	g/dL	31.50 - 34.50	
RDW (RBC histogram)	15.10	%	11.00 - 16.00	
<u>TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)</u>				
Total WBC Count	7730	/ μ L	4000.00 - 10000.00	
Neutrophil	[%] 60	%	EXPECTED VALUES 40.00 - 70.00	[Abs] / μ L 4638 EXPECTED VALUES 2000.00 - 7000.00
Lymphocyte	32	%	20.00 - 40.00	2474 / μ L 1000.00 - 3000.00
Eosinophil	03	%	1.00 - 6.00	232 / μ L 20.00 - 500.00
Monocytes	04	%	2.00 - 10.00	309 / μ L 200.00 - 1000.00
Basophil	0	%	0.00 - 2.00	0 / μ L 0.00 - 100.00
Band Cell	01	%	0 - 5	
Neut/Lympho Ratio (NLR)	1.88		0.78 - 3.53	
<u>Premature Cells</u>				
Premature Cells	Absent	%	Absent	
<u>PLATELET COUNT</u>				
Platelet Count	296000	/ μ L	150000.00 - 410000.00	
MPV	8.00	fL	6.5 - 12	
PDW	L 7.6	%	8 - 13	

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M.D.(Path)
Page 2 of 15

Dr. Prashant Naik

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SMEAR STUDY

RBC Morphology

**Hypochromasia(+)
Microcytosis(+)**

Platelet

Platelets are adequate in number.

Parasite

Malarial Parasite not seen on smear.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

1

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M.D.(Path)
Page 3 of 15

Dr. Prashant Naik

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C HPLC	H 6.00	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes As per ADA 2021 Guidelines	
Estimated Avg Glucose (3 Mths) <i>Calculated</i>	125.50	mg/dL	Not available	

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

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Page 4 of 15

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE REMARKS
BIOCHEMICAL INVESTIGATIONS			
Lipid Profile			
Cholesterol <i>Enzymatic</i>	149.0	mg/dL	<200 Desirable 200-239 Borderline >240 High
HDL Cholesterol <i>Accelerator Selective Detergent</i>	L 35.0	mg/dL	40 - 60
Triglyceride <i>Glycerol Phosphate Oxidase</i>	84.00	mg/dL	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High
VLDL <i>Calculated</i>	16.80	mg/dL	10 - 40
Chol/HDL <i>Calculated</i>	H 4.26		0 - 4.1
LDL Cholesterol <i>CALC</i>	97.20	mg/dL	<100 Optimal 100-129 Near optimal/above optimal 130-159 Borderline High 160-189 High >190 Very high
LDL/HDL Cholesterol	2.78		

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal<100	Desirable<200	Low<40	Normal<150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240	-	High 200-499
High 160-189	-	-	-

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment
- For LDL Cholesterol level Please consider direct LDL value
Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Detail test interpretation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment

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Page 5 of 15

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Page 6 of 15

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Plasma Glucose - F <i>Photometric, Hexokinase</i>	88.00	mg/dL	70.0 - 100	
BUN (Blood Urea Nitrogen) <i>GLDH</i>	7.5	mg/dL	7.00 - 18.70	
Uric Acid <i>Uricase</i>	2.90	mg/dL	2.6 - 6.0	
Creatinine <i>Kinetic Alkaline Picrate</i>	0.56	mg/dL	0.50 - 1.10	
Calcium <i>OCPC</i>	L 8.30	mg/dL	8.4 - 10.2	

Electrolytes

Sodium <i>ISE, Indirect</i>	138.00	mmol/L	136 - 145
Potassium <i>ISE, Indirect</i>	4.10	mmol/L	3.5 - 5.1
Chloride <i>ISE, Indirect</i>	107.00	mmol/L	98 - 107

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Page 7 of 15

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Sample Date and Time : 04-Jun-2025 11:21	Sample Coll. By : NAL	Ref Id1 :
Report Date and Time : 04-Jun-2025 12:50	Acc. Remarks :	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
Bilirubin Total <i>Colorimetric Diazo Method</i>	0.43	mg/dL	0.30 - 1.20	
Bilirubin Conjugated <i>Colorimetric Diazo Method</i>	0.18	mg/dL	0 - 0.50	
Bilirubin Unconjugated <i>Calculated</i>	0.25	mg/dL	0 - 0.8	
S.G.O.T. <i>NADH (Without P-5-P)</i>	13.00	U/L	11 - 34	
S.G.P.T. <i>NADH (Without P-5-P)</i>	15.00	U/L	0.0 - 34	
<u>Protein With A/G Ratio</u>				
Proteins (Total) <i>Biuret</i>	6.60	gm/dL	6.4 - 8.3	
Albumin <i>(BCG)</i>	3.50	gm/dL	3.5 - 5.2	
Globulin <i>Calculated</i>	3.10	gm/dL	2 - 4.1	
A/G Ratio <i>Calculated</i>	1.13		1.0 - 2.1	

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Page 8 of 15

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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R.A. Test <i>Immunoturbidimetric</i>	26.4	IU/mL	0 - 30	
RHEUMATOID FACTOR :				
Nephelometry is a gold standard, accurate, reliable, quantitative and specific method in comparison with other method.				
- Gives useful objective evidence of RA, but a negative result does not rule out RA. Negative in one-third of patients with definite RA. Positive result in <50% during first 6 mos of disease.				
- Titre may decrease during remission but rarely becomes negative. Progressive increases in titer during the first 2 yrs. decide a more severe course.				
- Positive in 5-10% of healthy population				
- Positive in 5% of rheumatoid variants				
- Positive in 5% of cases of scleroderma, connective, Polymyositis, Polymyalgia rheumatica.				
- Positive in 90% of patients with primary Sjogren syndrome or cryoglobulinemic purpura.				
- By this method we can detect RF from pleural fluid and synovial fluid also which are usually all the tie false positive by Latex Agglutination.				

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Report Date and Time : 04-Jun-2025 13:47	Acc. Remarks :	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Triiodothyronine (T3) CMIA	93.25	ng/dL	70 - 204	
Thyroxine (T4) CMIA	8.39	μg/dL	5.5 - 11.0	
TSH CMIA	3.153	μIU/mL	0.4 - 4.94	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 μIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 μIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipient hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a suppressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone.

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy Reference range (microIU/ml)

First trimester 0.24 - 2.00

Second trimester 0.43-2.2

Third trimester 0.8-2.5

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Page 10 of 15

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Interpretation Note:

Ultra sensitive-thyroid-stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone. Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). When the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.

Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.

Normal ranges of TSH & thyroid hormones vary according to trimester in pregnancy.

TSH ref range in Pregnancy	Reference range (microlU/ml)
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

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LABORATORY REPORT

Name : Mrs. KRISHNA MILAP DESAI	Sex/Age : Female / 50 Years	Case ID : 50603602392
Ref. By : Dr. Ashok U. Prajapati M.D.	Dis. At :	Pt. ID : 6055383
Bill. Loc. :		Pt. Loc. :
Reg Date and Time : 04-Jun-2025 11:28	Sample Type : Serum	Mobile No. : 9913120494
Sample Date and Time : 04-Jun-2025 11:21	Sample Coll. By : NAL	Ref Id1 :
Report Date and Time : 04-Jun-2025 13:47	Acc. Remarks :	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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VITAMIN B - 12 CMIA	L 178.0	pg/mL	211 - 911	
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Introduction :

Vitamin B12, a member of the corrin family, is a cofactor for the formation of myelin, and along with folate, is required for DNA synthesis. Levels above 300 or 400 are rarely associated with B12 deficiency induced hematological or neurological disease.

Clinical Significance :

Causes of Vitamin B12 deficiency can be divided into three classes: Nutritional, malabsorption syndromes and gastrointestinal causes. B12 deficiency can cause Megaloblastic anemia (MA), nerve damage and degeneration of the spinal cord. Lack of B12 even mild deficiencies damages the myelin sheath. The nerve damage caused by a lack of B12 may become permanently debilitating.

The relationship between B12 and MA is not always clear that some patients with MA will have normal B12 levels; conversely, many individuals with B12 deficiency are not afflicted with MA.

Decreased in:

Iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ileal damage, celiac disease, use of oral contraception, parasitic competition, pancreatic deficiency, treated epilepsy and advancing age.

Increased in:

Renal failure, liver disease and myeloproliferative diseases.

Variations due to age Increases: with age.

Temporarily Increased after Drug.

Falsely high in Deteriorated sample.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Prashant Naik

M.D.(Path),D.C.P.

Page 12 of 15

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
VITAMIN D				
25 OH Cholecalciferol (D2+D3) CMIA	36.70	ng/mL	Adult: 30 - 100 Normal Level 20 - <30 Insufficiency < 20 Deficiency > 150 Toxicity	Pediatric 20 - 100 Normal Level 15 - <20 Insufficiency < 15 Deficiency

25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g. due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

INTERPRETATION

Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.

Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)2-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)2-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.

Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH-VitD into the active form, 1,25 (OH)2-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D.

Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)2-VitD) levels are also overtly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients. CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

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Page 13 of 15

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
URINE EXAMINATION (STRIP METHOD AND FLOWCYTOMETRY)				

Physical examination

Colour Yellow

Appearance Clear

Chemical Examination By Sysmex UC-3500

Sp.Gravity	1.027	1.003 - 1.035
pH	5.5	4.6 - 8
Leucocytes (ESTERASE)	Negative	Negative
Protein	Negative	Negative
Glucose	Negative	Negative
Ketone Bodies Urine	Negative	Negative
Urobilinogen	Negative	Negative
Bilirubin	Negative	Negative
Blood	Negative	Negative
Nitrite	Negative	Negative

Flowcytometric Examination

Leucocyte	3-4	/HPF	Nil
Red Blood Cell	Nil	/HPF	Nil
Epithelial Cell	Few squamous & transitional	/HPF	Present(+)
Cast	Nil	/HPF	Nil
Crystals	Nil	/HPF	Nil

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Page 14 of 15

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Parameter	Unit	Expected value	Result/Notations				
			Trace	+	++	+++	++++
pH	-	4.6-8.0					
SG	-	1.003-1.035					
Protein	mg/dL	Negative (<10)	10	25	75	150	500
Glucose	mg/dL	Negative (<30)	30	50	100	300	1000
Bilirubin	mg/dL	Negative (0.2)	0.2	1	3	6	-
Ketone	mg/dL	Negative (<5)	5	15	50	150	-
Urobilinogen	mg/dL	Negative (<1)	1	4	8	12	-

Parameter	Unit	Expected value	Result/Notifications				
			Trace	+	++	+++	++++
Leukocytes (Strip)	/micro L	Negative (<10)	10	25	100	500	-
Nitrite(Strip)	-	Negative	-	-	-	-	-
Erythrocytes(Strip)	/micro L	Negative (<5)	10	25	50	150	250
Pus cells (Microscopic)	/hpf	<5	-	-	-	-	-
Red blood cells(Microscopic)	/hpf	<2	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

----- End Of Report -----

For test performed on specimens received or collected from non-NAL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NAL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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