



LAB REPORT

Customer Care Number  
9599593622  
9599593625

Accuracy Matters...



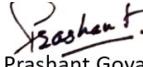
Barcode No	<b>90506494</b>	Lab No	09062504110132
Patient Name	<b>Master.PRIYEDARSHI</b>	Reg Date	11/Apr/2025 02:56PM
Age/Sex	12 YRS/Male	Sample Coll. Date	11/Apr/2025 02:01 PM
Referred By	SELF	Sample Rec.Date	11/Apr/2025 04:21 PM
Client Code/Name	AP010479 Dr. Sanjay Mahindru(HUF)	Report Date	11/Apr/2025 05:02PM
Ref. Lab/Hosp			
Panel Address	E1, Kiran Garden, Main Najafgarh Road, Opposite Metro Pillar No-712, Uttam Nagar,		

## Nirogyam Accuprobe Profile II

### HAEMATOLOGY

Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>Complete Blood Count (CBC EXT)</b>			
Haemoglobin Whole Blood EDTA, Cyanide free	14.4	gm/dl	11.5-15.5
TLC (Total Leucocyte Count) /(WBC) Whole Blood EDTA, Flow Cytometry	6.35	th/cumm	5.0-13.0
<b>DIFFERENTIAL LEUCOCYTE COUNT</b>			
Polymorphs Whole Blood EDTA Flowcytometry	46.9	%	32-62
Lymphocytes Flowcytometry	43.2	%	28-48
Eosinophils Flowcytometry	1.9	%	0-3
Monocytes Whole Blood EDTA Flowcytometry	<b>7.4</b>	%	0-4
Basophils Whole Blood EDTA Flowcytometry	0.6	%	0-1
Absolute Neutrophil Count Whole Blood EDTA, Flowcytometry	2,978	/cumm	2000-7000
Absolute Lymphocyte Count. Whole Blood EDTA, Flowcytometry	2,743	/µL	1000.0 - 3000.0
Absolute Eosinophil Count Whole Blood EDTA, Flowcytometry	121	/cumm	20-500
Absolute Monocyte Count Whole Blood EDTA, Flowcytometry	470	/cumm	20-1000
Absolute Basophils Count Whole Blood EDTA, Flowcytometry	38	/cumm	20-100
RBC Whole Blood EDTA, Impedance	5.2	millions/cmm	4.5-5.5
HCT Whole Blood EDTA, Calculated	<b>47.1</b>	%	35-45
MCV Whole Blood EDTA, Calculated	90.58	fL	77-95
MCH	27.69	pg	25-33



  
Dr. Prashant Goyal (DCP)  
(Director & Chief Pathologist)  
Reg. No. DMC-53016



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Whole Blood EDTA, Calculated			
<b>MCHC</b>	<b>30.57</b>	g/dl	31-37
Whole Blood EDTA, Calculated			
<b>Platelet Count</b>	<b>174</b>	thou/ $\mu$ L	170-450
Whole Blood EDTA, Impedance			
<b>MPV</b>	<b>13.3</b>	fL	7.4-10.4
Calculated			
<b>RDW- CV</b>	<b>15.2</b>	%	11.6-14.0
Whole Blood EDTA, Flowcytometry			
<b>RDW- SD</b>	<b>50.9</b>	fL	35-56
Whole Blood EDTA, Flowcytometry			
<b>PCT</b>	<b>0.2</b>	%	0.10-0.28
Whole Blood EDTA, Flow Cytometry			
<b>PDW</b>	<b>16.3</b>	fL	9.0-17.0
Whole Blood EDTA, Calculated			
<b>Mentzer Index</b>	<b>17.42</b>	Ratio	
<b>RDWI</b>	<b>264.77</b>		
<b>Green and King</b>	<b>86.61</b>		
<b>Neutrophil - Lymphocyte Ratio (NLR)</b>	<b>1.09</b>	Ratio	
Calculated			
<b>Lymphocyte - Monocyte Ratio (LMR)</b>	<b>5.84</b>	Ratio	
Calculated			
<b>Platelet - Lymphocyte Ratio (PLR)</b>	<b>63.43</b>	Ratio	
Calculated			
<b>ESR [Westergren]</b>	<b>10</b>	mm/ 1 hr	0 -15
Modified Westergren			

Kindly correlate clinically. Advise for recheck from fresh sample in case, it is not correlation clinically, to rule out any pre-analytical error.

Referrance range according to Practical Haematology, Dacie & Lewis, 12th edition, 2012.



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MC-2097



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<b>Test Name With Methodology</b>	<b>Result</b>	<b>Unit</b>	<b>Biological Ref.Interval</b>
<b>.IMMUNO BIOCHEMISTRY-1</b>			

### **Glucose Fasting (Blood Glucose Fasting)**

Blood Sugar Fasting	88	mg/dL	70-100
Plasma Fluoride, Hexokinase			

**COMMENTS:**

Fasting Blood Sugar/Glucose test. A blood sample will be taken after an overnight fast. A fasting blood sugar level less than 100 mg/dL is normal. A fasting blood sugar level from 100 to 125 mg/dL is considered prediabetes. If it's 126 mg/dL or higher on two separate tests, you have diabetes. (**American Diabetes Association**)



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Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>HAEMATOLOGY</b>			

**HbA1c (Glycated hemoglobin)**

Glycosylated Hb (HbA1c) EDTA, HPLC	5.2	%	4.2-6.5
Average Glucose	103	mg/dl	73-140

Calculated.

**Ref Range for HbA1c**

Non Diabetic:	< 5.7 %
Pre-Diabetic:	5.7 - 6.5 %
Diabetic:	> 6.5 %

Remark: Hemoglobin A1c criteria for diagnosing diabetes have not been established for patients who are &lt;18 years of age.

**HbA1c goals in treatment of diabetes:**

Ages 0-6 years:	7.6% - 8.4%
Ages 6-12 years:	<8%
Ages 13-19 years:	<7.5%
Adults:	<7%

**COMMENT:**

The Glycosylated Hemoglobin (HbA1c or A1c) test evaluates the average amount of glucose in the blood over the last 2 to 3 months. This test is used to monitor treatment in someone who has been diagnosed with diabetes. It helps to evaluate how well the person's glucose levels have been controlled by treatment over time. This test may be used to screen for and diagnose diabetes or risk of developing diabetes. Depending on the type of diabetes that a person has, how well their diabetes is controlled, and on doctor recommendations, the HbA1c test may be measured 2 to 4 times each year. The American Diabetes Association recommends HbA1c testing in diabetics at least twice a year. When someone is first diagnosed with diabetes or if control is not good, HbA1c may be ordered more frequently.

**Note: If a person has anemia, few type of hemoglobinopathy, hemolysis, or heavy bleeding, HbA1c test results may be falsely low. If someone is iron-deficient, the HbA1c level may be increased. If a person has had a recent blood transfusion, the HbA1c may be inaccurate and may not accurately reflect glucose control for 2 to 3 months..**



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Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>.IMMUNO BIOCHEMISTRY-1</b>			

**Iron Panel Basic**

Iron	95.5	ug/dl	28-112
Serum, FerroZine without deproteinization			
UIBC	205	ug/dL	63 - 433
Direct determination with FerroZine			
TIBC	300	ug/dL	250 - 400
Serum, Calculated			
Transferrin Saturation	31.78	%	15-55
Calculated			

**COMMENT:**

Serum iron measures the amount of circulating iron that is bound to transferrin. Clinicians order this laboratory test when they are concerned about iron deficiency, which can cause anemia and other problems.

Total iron-binding capacity The test measures the extent to which iron-binding sites in the serum can be saturated. Because the iron-binding sites in the serum are almost entirely dependent on circulating transferrin, this is really an indirect measurement of the amount of transferrin in the blood. Taken together with serum iron and percent transferrin saturation clinicians usually perform this test when they are concerned about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, liver function must be considered when performing this test. It can also be an indirect test of liver function, but is rarely used for this purpose.



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Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>Kidney Panel-2</b>			
Blood Urea Serum, Urease, GLDH	21.10	mg/dL	15-36.0
Serum Creatinine. Serum, Jaffes	0.80	mg/dL	0.7-1.2
Uric Acid Enzymatic colorimetry	<b>7.48</b>	mg/dL	3.4 - 7.0
Sodium Serum, Ion Selective Electrode	136	mmol/L	136-145
Potassium Serum, Ion Selective Electrode	4.5	mmol/L	3.7-5.5
Chloride Serum, Ion Selective Electrode	100.00	mmol/L	98-107
Calcium. Serum, NM-BAPTA	9.98	mg/dL	8.8-10.8
Phosphorus Serum Serum, Molybdate UV	4.28	mg/dl	2.5-4.5
BUN (Blood Urea Nitrogen ) Serum, Calculated	9.86	mg/dL	4.0-18.0
BUN/Creatinine Ratio Calculated	12.33	Ratio	10-20
Urea/Creatinine Ratio Calculated	26.38	Ratio	
eGFR (estimated Glomerular Filtration Rate) Calculated	145.54	mL/min/1.73 m2	>60

The National Kidney Foundation recommends using the Estimated GFR using MDRD Creatinine Equation (2021) to estimate GFR. (<http://surl.li/lwau>)

*Kindly correlate clinically. Advise for recheck from fresh sample in case, it is not correlation clinically, to rule out any pre-analytical error.*



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**Test Name With Methodology**      **Result**      **Unit**      **Biological Ref.Interval**
**Lipid Profile**

Cholesterol Serum, CHOD-PAP Enzymatic	117.0	mg/dL	<200
Triglyceride Serum, GPO, Colorimetric	131.0	mg/dL	<150
HDL-Cholesterol Serum, Homogeneous Enz.Colorimetric	44.1	mg/dL	40-60
LDL Cholesterol Serum, Calculated	46.8	mg/dl	0-100
VLDL Cholesterol Serum, Calculated	26.2	mg/dl	5 - 40
LDL / HDL Ratio Serum, Calculated	1.06	Ratio	0 - 3.55
HDL / LDL Ratio Serum, Calculated	0.94	Ratio	>0.3
Chol / HDL Ratio Serum, Calculated	2.65	Ratio	0 - 4.97
Non-HDL Cholesterol Serum, Calculated	72.9	mg/dl	<160

Lipids are a group of fats and fat-like substances that are important constituents of cells and sources of energy. The lipid profile is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease. It is recommended that healthy adults with no other risk factors for heart disease be tested with a fasting lipid profile once every four to six years. If other risk factors are present or if previous testing revealed a high cholesterol level in the past, more frequent testing is recommended.

TOTAL CHOLESTEROL	(mg/dl)	HDL	(mg/dl)	LDL	(mg/dl)	TRIGLYCERIDES	(mg/dl)
DESIRABLE	<200	LOW	<40	OPTIMAL	<100	NORMAL	<150
BORDERLINE HIGH	200-239	HIGH	>60	NEAR OPTIMAL	100-129	BORDERLINE HIGH	150-199
HIGH	>240			BORDERLINE HIGH	130-159	HIGH	200-499
				HIGH	160-189	VERY HIGH	>500
				VERY HIGH	>190		

\*REFERENCE RANGES AS PER NCEP ATP III GUIDELINES



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Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>Liver Panel (LFT)</b>			
Total Bilirubin. Serum, DCA	0.49	mg/dl	0.0-1.2
Conjugated Bilirubin Serum, DCA	0.13	mg/dl	0.0-0.3
Unconjugated Bilirubin Serum, Calculated	0.36	mg/dL	0.2-0.7
SGOT (AST) Serum, Optimized UV test with IFCC	24.60	IU/L	0 -40
SGPT (ALT) Serum, Optimized UV test with IFCC	14.10	IU/L	0-41
Alk.Phosphatase Serum, Kinetic, IFCC	<b>127.00</b>	IU/L	129-417
T.Protein Serum, Biuret	7.76	gm/dl	6.4-8.3
Albumin.. Serum, Bromocresol Green	4.50	gm/dL	3.5-5.2
Globulin Serum, Calculated	3.26	gm/dl	2.3- 3.5
A/G Ratio Serum, Calculated	1.38	Ratio	1.30 - 1.70
Gamma G.T. Serum, Kinetic with IFCC	10.90	IU/L	<60
SGOT/SGPT Ratio Serum, Calculated	1.74	Ratio	0-5

**Comment:**

A liver panel (Liver function test) or one or more of its component tests may be used to help diagnose liver disease if a person has symptoms that indicate possible liver dysfunction. If a person has a known condition or liver disease, testing may be performed at intervals to monitor liver status and to evaluate the effectiveness of any treatments.



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**Test Name With Methodology**      **Result**      **Unit**      **Biological Ref.Interval**
**Thyroid Profile-I [T3,T4,TSH]**

T3 (Triiodothyronine) Serum, Chemi Luminescent Immuno Assay	138.09	ng/dl	91-218
T4 (Thyroxine) Serum, Chemi Luminescent Immuno Assay	8.35	ug/dl	5.91-13.2
TSH (Ultrasensitive) Serum, Electro Chemi Luminescent Immuno Assay	1.53	uIU/mL	0.51-6.50

## Comments:

- Our reference range applies the central 95th interval (2.5th – 97.5th quantile) according to the CLSI/IFCC guidelines EP28-A3c.
- A circadian variation in serum TSH in healthy subjects is well documented. TSH level is reaching peak levels between 2-4 am 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 value of TSH.
- TSH levels between 6.3 and 15.0 may represent subclinical or compensated hypothyroidism or show considerable physiological & seasonal variation, suggest clinical correlation or repeat testing with fresh sample.
- TSH levels may be transiently altered because of non-thyroid illness, like severe infection, renal disease, liver disease, heart disease, severe burns, trauma, surgery etc. Few drugs also alter the TSH values.
- A high TSH result often means an underactive thyroid gland caused by failure of the gland (hypothyroidism). A low TSH result can indicate an overactive thyroid gland (hyperthyroidism) or damage to the pituitary gland that prevents it from producing TSH.
- Resistance to thyroid hormone (RTH) and central hyperthyroidism (TSH-oma) are rare conditions associated with elevated TSH, T4 and T3 levels.

Below mentioned are the guidelines for age reference ranges for T3,T4 and TSH results:

Age	Total T3 (ng/dl)	Total T4 ( μg/dl)	TSH (μIU/ml)
1 - 6 days	73 - 288	5.04 - 18.5	0.7 - 15.0
6 days - 3 months	80 - 275	5.41 - 17.0	0.72 - 11.0
4 - 12 months	86 - 265	5.67 - 16.0	0.73 - 8.35
1 - 6 years	92 - 248	5.95 - 14.7	0.70 - 5.97
7 - 11 years	93 - 231	5.99 - 13.8	0.60 - 5.84
12 - 20 years	91 - 218	5.91 - 13.2	0.51 - 6.50
>20 years	60 - 181	4.50 - 12.6	0.13 - 6.33

## TSH Level in pregnancy

First Trimester	0.10 - 2.5 μIU/ml
Second Trimester	0.20 - 3.0 μIU/ml
Third Trimester	0.30 - 3.0 μIU

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Reg. No. DMC-90705



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<b>CLINICAL PATHOLOGY</b>			

**Urine R/M (Urine Analysis)****PHYSICAL EXAMINATION**

Color	Pale Yellow	
Urine, Visual Transparency	Clear	Clear
Visual		
pH	5.5	4.7-7.5

Specific Gravity	1.025	1.005-1.035
------------------	-------	-------------

**CHEMICAL EXAMINATION**

Urine Glucose	Negative	Negative
Urine, Oxidation reaction		
Urine Protein.	Negative	Negative
Urine, Protein ionization		
Urine Bilirubin	Negative	Negative
Urine, Azo- coupling reaction		
Ketones	Negative	Negative
Urine, Acetoacetate and nitroprusside reaction		
Urobilinogen	Normal	Normal
Urine, p-aminobenzoic acid and phenazopyridine reaction		
Nitrate	Negative	Negative
Urine, Diazotized reaction		
Blood	Negative	Negative
Urine, peroxidase reaction		
Leukocytes Est	Negative	Negative
Urine, Esterases		

**MICROSCOPIC EXAMINATION**

Pus Cells.	1-2	/hpf	0-5
Urine, Manual Microscopic			
Epithelial Cells	0-2	/hpf	0-5
Urine, Manual Microscopic			
R.B.C.	Not Seen	/hpf	Not Seen
Manual Microscopic			
Crystals	Not Seen	/hpf	Not Seen



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Urine, Manual Microscopic

Casts

Not Seen

/lpf

Not Seen

Urine, Manual Microscopic

Bacteria

Not Detected

Not Detected

Manual Microscopic



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Referred By	SELF	Sample Rec.Date	11/Apr/2025 04:21 PM
Client Code/Name	AP010479 Dr. Sanjay Mahindru(HUF)	Report Date	11/Apr/2025 08:40PM
Ref. Lab/Hosp			
Panel Address	E1, Kiran Garden, Main Najafgarh Road, Opposite Metro Pillar No-712, Uttam Nagar,		

Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>.IMMUNO BIOCHEMISTRY-1</b>			

**Vitamin B12 (Cynocobalamin)**

Vitamin B12 Level <small>Serum, Electro Chemi Luminescent Immuno Assay</small>	<b>171.0</b>	pg/ml	197-711
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**Comment:**

Vitamin B12 (cobalamin) is an important water-soluble vitamin. In contrast to other water-soluble vitamins it is not excreted quickly in the urine, but rather accumulates and is stored in the liver, kidney and other body tissues. Humans obtain Vitamin B12 exclusively from animal dietary sources, such as meat, eggs and milk. As a result, a vitamin B12 deficiency may not manifest itself until after 5 or 6 years of a diet supplying inadequate amounts. Vitamin B12 functions as a methyl donor and works with folic acid in the synthesis of DNA and red blood cells and is vitally important in maintaining the health of the insulation sheath (myelin sheath) that surrounds nerve cells. Preservatives such as fluorides & ascorbic acid interfere with this assay. Excessive exposure of the specimen to light may alter Vitamin B12 result.

**Kindly correlate with clinical conditions.**

Dr. Anuja Adarsh, MBBS, MD  
(Consultant Biochemist)  
Reg. No. DMC-90705



Dr. Prashant Goyal (DCP)  
(Director & Chief Pathologist)  
Reg. No. DMC-53016





LAB REPORT

Customer Care Number  
9599593622  
9599593625

Accuracy Matters...



Barcode No	<b>90506494</b>	Lab No	09062504110132
Patient Name	<b>Master.PRIYEDARSHI</b>	Reg Date	11/Apr/2025 02:56PM
Age/Sex	12 YRS/Male	Sample Coll. Date	11/Apr/2025 02:01 PM
Referred By	SELF	Sample Rec.Date	11/Apr/2025 04:21 PM
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Ref. Lab/Hosp			
Panel Address	E1, Kiran Garden, Main Najafgarh Road, Opposite Metro Pillar No-712, Uttam Nagar,		

Test Name With Methodology	Result	Unit	Biological Ref.Interval
<b>Vitamin D (25 Hydroxyvitamin D)</b>			
Vitamin D, 25 Hydroxy <small>Serum, Electro Chemi Luminescent Immuno Assay</small>	<b>5.10</b>	ng/mL	Deficiency: <20.0 Insufficient: 21-29 Sufficient: 30-100

**Comments:**

This test is used to determine the levels of Total 25-hydroxy-vitamin D and is used to determine if bone weakness, bone malformation, or abnormal metabolism of calcium is occurring as a result of a deficiency or excess of vitamin D. Since vitamin D is a fat-soluble vitamin and is absorbed from the intestine like a fat, vitamin D is also used to monitor individuals with diseases that interfere with fat absorption, such as cystic fibrosis and Crohn's disease, and in patients who have had gastric bypass surgery and may not be able to absorb enough Vitamin D. Vitamin D is also used to determine effectiveness of treatment when vitamin D, calcium, phosphorus, and/or magnesium supplementation is prescribed. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, inadequate intake; malabsorption eg, 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. In contrast to the high prevalence of 25-OH-VitD deficiency, 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.

**For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.**

Dr. Anuja Adarsh, MBBS, MD  
(Consultant Biochemist)  
Reg. No. DMC-90705



Dr. Prashant Goyal (DCP)  
(Director & Chief Pathologist)  
Reg. No. DMC-53016



# Chromatogram Report

HLC-723G11-2 V3.09 2 2025-04-11 17:07:56

ID 90506494

Sample No. 2025041117090264 SL 0003 - 03

Patient ID

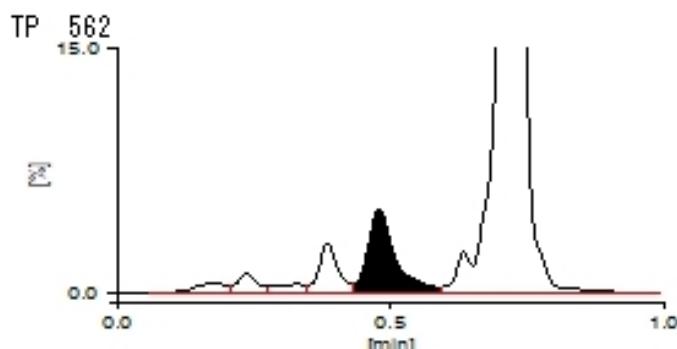
Name

Comment

CALIB(N)	$Y = 1.1013X + 0.7030$		
Name	%	Time	Area
FP			
A1A	0.6	0.18	11.28
A1B	0.7	0.24	14.14
F	0.5	0.33	9.59
LA1C+	1.6	0.38	33.19
SA1C	5.2	0.48	82.15
A0	93.1	0.71	1892.17
H-VAR			
	Total Area		2042.52

HbA1c 5.2 %

HbF 0.5 %



## Terms & Conditions

- The reported results are for the information of the referring doctor and should be correlated to clinical diagnosis.
- In case of insufficient quantity or poor quality of specimen test will not be performed. In such cases it is expected that fresh specimen is sent for reporting of the same parameter.
- There may be circumstances beyond our control that can delay results, e.g., invalid assay run.
- The results of a laboratory test are dependent on the quality of the sample as well as the assay procedure.
- The report is to be interpreted and used by medical personnel only.
- This report is not intended for medico-legal purpose.
- Assays are performed in accordance with standard procedures. Results may vary from time to time and from lab to lab for the same parameter for the same patient. The reported results are dependent on individual assay method or equipments used and quality of specimen(s) received. Investigations have their limitations and isolated laboratory investigations may not confirm the final diagnosis of disease. They only assist in arriving at diagnosis in conjunction with clinical presentation and other related investigations.
- For the test performed on specimens received or collected from different locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request form and such verification has been carried out at the point of generation of the said specimen by the sender.
- Accuprobe will be responsible only for the analytical part of the test carried out. All other responsibility will be of referring Laboratory.
- If any dispute arises in future party can file the suit in the court of law with the jurisdiction within Delhi jurisdiction only.

----- End of Report -----

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### OUR REGIONAL LABORATORIES

#### ACCUPROBE DIAGNOSTICS, BATHINDA

Accuprobe Diagnostics : UID No. Z-4-01754-000-000, Agarwal Colony, Near Kabir Medical Store, Bathinda, Punjab - 151001

#### ACCUPROBE DIAGNOSTICS, GUWAHATI

Accuprobe Diagnostics : Jaya Nagar Chariali, Near SBI IIBM Branch Tripura Road, Beltola Guwahati-781028

#### ACCUPROBE DIAGNOSTICS, JAIPUR

Accuprobe Diagnostics : 8-A, 2<sup>nd</sup> Floor, Sudershanpura Industrial Area, Bais Godown, Jaipur - 302006 | Mob : 9289485990

#### ACCUPROBE DIAGNOSTICS, KANPUR

Accuprobe Diagnostics : 86/275-A3, Afim Kothi, GT Road, Kanpur, Uttar Pradesh - 208003

#### ACCUPROBE DIAGNOSTICS, KOLKATA

Accuprobe Diagnostics : 1<sup>st</sup> Floor of the Premises No. 2 Hemachandra Naskar Road, Police Station and Post Office, Kolkata - 700010 | Mob: 8929130368

#### ACCUPROBE DIAGNOSTICS, PATNA

Accuprobe Diagnostics : Office No.-205, 2<sup>nd</sup> Floor, NBCC Commercial Tower, Bahadurpur Housing Colony, Patna, Bihar - 800026 | Mob : 8929130367

#### ACCUPROBE DIAGNOSTICS, CHANDIGARH

Accuprobe Diagnostics : SCO No. 20, Second Floor, Phase-2, Sector-54 Mohali, SAS Nagar, Punjab-160055 | Mob: 8929130370

#### ACCUPROBE DIAGNOSTICS, HAILAKANDI (ASSAM)

Accuprobe Diagnostics : New Aroti Diagnostics, Ward no. 3, Mission Road Hailakandi - 788155 (Assam) | Mob.: 9707629449, 9707629450

#### ACCUPROBE DIAGNOSTICS, JALANDHAR

Accuprobe Diagnostics : 237, 1<sup>st</sup> Floor, Above ICICI Bank, Adarsh Nagar, Near Chick Chick Chowk, Jalandhar, Punjab - 144001 | Mob: 8929130369

#### ACCUPROBE DIAGNOSTICS, KARNAL

Accuprobe Diagnostics : Property Bearing No.- 44, Opposite TVS Green Showroom, Arjun Gate Near Kalandari Gate, Karnal, Haryana - 132001 | Mob : 9992990694

#### ACCUPROBE DIAGNOSTICS, MORADABAD

Accuprobe Diagnostics : A-64, Gandhi Nagar, Moradabad - 244001, Uttar Pradesh | Mob : 9289485985

#### ACCUPROBE DIAGNOSTICS, SAHARANPUR

Accuprobe Diagnostics : H.No. 3/5777, Prakash Puram, Janakpuri, Opposite - Bahoria Civil Hospital, Saharanpur, Uttar Pradesh - 247001 | Mob : 8929312410

#### ACCUPROBE DIAGNOSTICS, SRINAGAR

Accuprobe Diagnostics : Near Apollo Clinic, Shah Complex, Main Chowk Karan Nagar, Srinagar - 190010 (J&K) | Mob.: 9205882054



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