



Lab Facility : 3rd Floor, Vanita Vishram Building, Above Barmi Motoda, Athwa Gate Circle, Surat - 395 001. Ph.: 0261-6720000 / Mobile: 9714971114, 9016961266  
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 Out source Lab USLL Ahmedabad : Unipath House, Beside Sahjanand college, Opposite Kamdeno Complex, Panjarapole, Ambawadi, Ahmedabad-380015  
 Unigenome: 2A,3A,3B PASL -House, Beside Sahjanand college, Opposite Kamdeno Complex, Panjarapole, Ambawadi, Ahmedabad-380015, Gujarat  
**Phone:** 07699991171 | **Email:** info@unipath.in | **Website:** www.unipath.in

## TEST REPORT

Reg. No.	: 51000722587	Reg. Date :	20-Oct-2025 06:14	Ref.No :	Approved On : 20-Oct-2025 11:23
Name	: Mr. SAISH UMESH PATIL			Collected On	: 20-Oct-2025 06:14
Age	: 22 Years	Gender:	Male	Pass. No. :	Dispatch At :
Ref. By	: Dr. SAVITA PATIL M.B.B.S (GYNEC)			Tele No.	:
Location	: ATHARV CLINICAL LABORATORY @ SHIRPUR				

Test	Results	Unit	Bio. Ref. Interval
<b>Complete Blood Count</b> <u>Specimen: EDTA blood</u>			
Hemoglobin(SLS method)	16.7	g/dL	13.0 - 17.0
Hematocrit(ele. impedance)	H 53.7	%	40 - 50
RBC Count(ele. impedance)	H 6.17	$\times 10^{12}/L$	4.5 - 5.5
WBC Count(Flowcytometry)	9130	/cmm	4000 - 10000
Platelet Count(ele. impedance)	278000	/cmm	150000 - 410000
MCV(Calculated)	87.0	fL	83 - 101
MCH(Calculated)	27.1	pg	27 - 32
MCHC(Calculated)	L 31.1	g/dL	31.5 - 34.5
RDW(Calculated)	14.5	%	11.5 - 14.5

### DIFFERENTIAL WBC COUNT

Neutrophils	55	%	38 - 70
Lymphocytes	35	%	21 - 49
Monocytes	06	%	3 - 11
Eosinophils	04	%	0 - 7

NLR (Neutrophil: Lymphocyte Ratio)	1.57	Ratio	1.1 - 3.5
Platelets appear on the smear	Adequate		
Malarial Parasites	Not Detected		

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*Dhaval*

Dr. Dhaval Bamania  
Pathologist  
G-16880

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Ref. By	: Dr. SAVITA PATIL M.B.B.S (GYNEC)				Tele No.	:
Location	: ATHARV CLINICAL LABORATORY @ SHIRPUR					

Test Name	Results	Units	Bio. Ref. Interval
Alanine Aminotransferase (SGPT)	29.38	U/L	0 - 41
UV without P5P			
Alkaline Phosphatase (ALP)	52.00	U/L	40 - 130
IFCC.PNP,AMP Buffer			
Aspartate Aminotransferase (SGOT)	14.04	U/L	0 - 40
UV without P5P			

Alkaline phosphatase (ALP) is present in a number of tissues including liver, bone, intestine, and placenta. The activity of ALP found in serum is a composite of isoenzymes from those sites and, in some circumstances, placental or Regan isoenzymes. Serum ALP is of interest in the diagnosis of 2 main groups of conditions: hepatobiliary disease and bone disease associated with increased osteoblastic activity. A rise in ALP activity occurs with all forms of cholestasis, particularly with obstructive jaundice. The response of the liver to any form of biliary tree obstruction is to synthesize more ALP. The main site of new enzyme synthesis is the hepatocytes adjacent to the biliary canaliculi. ALP is also elevated in disorders of the skeletal system that involve osteoblast hyperactivity and bone remodeling, such as Paget disease, rickets, osteomalacia, fractures, and malignant tumors. Moderate elevation of ALP may be seen in other disorders such as Hodgkin disease, congestive heart failure, ulcerative colitis, regional enteritis, and intra-abdominal bacterial infections.

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Aspartate Aminotransferase (SGOT)

14.04

U/L

0 - 40

UV without P5P

Sample Type: Serum  
AST is a liver enzyme that is also found in the heart, skeletal muscle and kidney. AST has two isoenzymes that are found in either the mitochondria or cytoplasm in cells. Alcohol-induced hepatocyte injury induces predominantly mitochondrial damage. AST requires vitamin B6 as a co factor for the enzymatic reaction. Decreased levels may indicate vitamin B6 deficiency and uremia. AST is most commonly used in conjunction with ALT or LDH. The Deritis ratio (AST/ALT quotient) is found to be elevated in alcohol induced liver disease, viral hepatitis, cirrhosis and acute fulminant hepatic failure. A ratio of >2 suggests alcohol as cause of liver injury.

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Dr. Brijesha Patel  
M.D. Pathology  
Reg. No.: G-32437

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Location	ATHARV CLINICAL LABORATORY @ SHIRPUR						

Test Name	Results	Units	Bio. Ref. Interval
<b>ELECTROLYTES</b>			
Sodium (Na <sup>+</sup> ) <small>Method ISE</small>	137.70	mmol/L	136 - 145
Potassium (K <sup>+</sup> ) <small>Method ISE</small>	4.2	mmol/L	3.5 - 5.1
Chloride(Cl <sup>-</sup> ) <small>Method ISE</small>	101.8	mmol/L	98 - 107

**Sample Type: Serum**

**NOTE:**  
 The electrolyte panel is ordered to identify electrolyte, fluid, or pH imbalance. Electrolyte concentrations are evaluated to assist in investigating conditions that cause electrolyte imbalances such as dehydration, kidney disease, lung diseases, or heart conditions. Repeat testing of the electrolyte or its components may be used to monitor the patient's response to treatment of any condition that may be causing the electrolyte, fluid or pH imbalance.

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Location	: ATHARV CLINICAL LABORATORY @ SHIRPUR						

Test Name	Results	Units	Bio. Ref. Interval
<b>SERUM BILIRUBIN ESTIMATION</b>			
Specimen: Serum			
TOTAL BILIRUBIN	0.37	mg/dL	<1.1
DIRECT BILIRUBIN	0.18	mg/dL	<=0.2
INDIRECT BILIRUBIN	0.19	mg/dL	0.0 - 1.00

### Sample Type: Serum

Bilirubin is one of the most commonly used tests to assess liver function. Approximately 85% of the total bilirubin produced is derived from the heme moiety of hemoglobin, while the remaining 15% is produced from RBC precursors destroyed in the bone marrow and from the catabolism of other heme-containing proteins. After production in peripheral tissues, bilirubin is rapidly taken up by hepatocytes where it is conjugated with glucuronic acid to produce bilirubin mono- and diglucuronide, which are then excreted in the bile. The most commonly occurring form of unconjugated hyperbilirubinemia is that seen in newborns and referred to as physiological jaundice. The increased production of bilirubin, that accompanies the premature breakdown of erythrocytes and ineffective erythropoiesis, results in hyperbilirubinemia in the absence of any liver abnormality. In hepatobiliary diseases of various causes, bilirubin uptake, storage, and excretion are impaired to varying degrees. Thus, both conjugated and unconjugated bilirubins are retained and a wide range of abnormal serum concentrations of each form of bilirubin may be observed. Both conjugated and unconjugated bilirubins are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater.

Reference range For New born:

Cord( Premature) : <2.0 mg/dL

Cord( full term) ) : <2.0 mg/dL

0-1 days (Premature) : 1-8 mg/dL

0-1 days (Full term) : 2-6 mg/dL

1-2 days (Premature) : 6-12 mg/dL

1-2 days (Full term) : 6-10 mg/dL

3-5 days (Premature) : 10.0-14.0 mg/dL

3-5 days (Full term) : 4.0-8.0 mg/dL

Useful for:

- Assessing liver function
- Evaluating wide range of diseases affecting the production, uptake, storage, metabolism, excretion of bilirubin.
- Monitoring the efficacy of neonatal phototherapy.

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Ref. By	: Dr. SAVITA PATIL M.B.B.S (GYNEC)				Tele No.	:
Location	: ATHARV CLINICAL LABORATORY @ SHIRPUR					

Test Name	Results	Units	Bio. Ref. Interval
			Protein with A/G ratio
			Specimen - Serum
TOTAL PROTEIN <small>Method Biuret</small>	7.64	g/dL	6.4 - 8.3
ALBUMIN <small>Method Bromocresol-Green</small>	4.63	g/dL	3.97 - 4.94
GLOBULIN <small>Calculated</small>	3.01	g/dL	2.4 - 3.5
ALB/GLB Ratio <small>Calculated</small>	1.54		1.2 - 2.2

**Sample Type: Serum****CLINICAL SIGNIFICANCE:**

- Changes in the relative percentage of plasma proteins can be due to a change in the percentage of one plasma protein fraction. Often in such cases the amount of total protein does not Change.
- The A/G ratio is commonly used as an index of the distribution of Albumin and globulin fractions.
- Marked changes in this ratio can be Observed in cirrhosis of the liver, glomerulonephritis, nephrotic syndrome, Acute hepatitis, lupus erythematosus as well as in certain acute and chronic Inflammations.
- Total protein measurements are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney, or bone Marrow, as well as other metabolic or nutritional disorders

**HYPOPROTEINEMIA:**

- Loss Of Blood,
- Sprue,
- Nephrotic Syndrome,
- Severe Burns,
- Salt Retention Syndrome
- Kwashiorkor (Acute Protein Deficiency).

**HYPERTROPEINEMIA:**

- Severe Dehydration
- Multiple Myeloma.

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Location	ATHARV CLINICAL LABORATORY @ SHIRPUR						

Test Name	Results	Units	Bio. Ref. Interval
<u>LIPID PROFILE</u>			
CHOLESTEROL <small>Method Cholesterol Oxidase, Peroxidase</small>	H 205.19	mg/dL	<200 : Desirable, 200-239 : Borderline High, >=240 : High
Triglyceride (TG) <small>Method GPC-POD</small>	132.40	mg/dL	<150 : Normal, 150-199 : Border Line High, 200-499 : High, >=500 : Very High
Very Low Density Lipoprotein(VLDL) <small>Method Calculated</small>	26.48	mg/dL	0 - 30
Low-Density Lipoprotein (LDL) <small>Method Calculated</small>	H 132.30	mg/dL	< 100 : Optimal, 100-129 : Near Optimal/above optimal, 130-159 : Borderline High, 160-189 : High, >=190 : Very High
High-Density Lipoprotein(HDL) <small>Method Homogeneous Enzymatic Colorimetric</small>	46.41	mg/dL	<40 Low (High Risk), >=60 High(Low Risk)
CHOL/HDL RATIO <small>Method Calculated</small>	H 4.42		0.0 - 3.5
LDL/HDL RATIO <small>Method Calculated</small>	2.85		1.0 - 3.4
TOTAL LIPID <small>Calculated</small>	635.18	mg/dL	400 - 1000

**Sample Type: Serum**
**Note:**

As a routine test to determine if your cholesterol level is normal or falls into a borderline-, intermediate- or high-risk category.

To monitor your cholesterol level if you had abnormal results on a previous test or if you have other risk factors for heart disease.

To monitor your body's response to treatment, such as cholesterol medications or lifestyle changes.

To help diagnose other medical conditions, such as liver disease.

Note : biological reference intervals are according to the national cholesterol education program ( NCEP) guidelines.

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Location	: ATHARV CLINICAL LABORATORY @ SHIRPUR						

Test Name	Results	Units	Bio. Ref. Interval
<b>THYROID FUNCTION TEST</b>			
Triiodothyronine(Total T3) <small>Method CLIA</small>	1.15	ng/mL	0.6 - 1.81
Thyroxine(Total T4) <small>Method CLIA</small>	6.8	µg/dL	4.5 - 12.6
TSH (Ultra Sensitive) <small>Method CLIA</small>	1.343	µIU/mL	0.55 - 4.78

**Sample Type: Serum**

**Comments:**

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

**TSH levels During Pregnancy :**

- First Trimester : 0.1 to 2.5 µIU/mL
- Second Trimester : 0.2 to 3.0 µIU/mL
- Third trimester : 0.3 to 3.0 µIU/mL

Reference : Carl A.Burtis,Edward R.Ashwood,David E.Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition. Philadelphia: WB Sounders,2012:2170

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ISO 15189:2012

CNR UMS1963L2009PLC7769

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Location	: ATHARV CLINICAL LABORATORY @ SHIRPUR				

Test Name	Results	Units	Bio. Ref. Interval
<b>HbA1C (GlyoHb)</b>			
HbA1c HPLC	4.90	%	Normal: <= 5.6 Prediabetes: 5.7-6.4 Diabetes: >= 6.5
Mean Blood Glucose (Calculated)	94	mg/dL	

Sample Type: EDTA Whole Blood

**Criteria for the diagnosis of diabetes**

1. HbA1c  $\geq 6.5$  \* Or Fasting plasma glucose  $> 126 \text{ gm/dL}$ . Fasting is defined as no caloric intake at least for 8 hrs. Or
2. Two hour plasma glucose  $\geq 200 \text{ mg/dL}$  during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water. Or
3. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq 200 \text{ mg/dL}$ . \*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34:S11.

**Limitation of HbA1c**

- 1) In patients with Hb variants even analytically correct results do not reflect the same level of glycemic control that would be expected in patients with normal population.
  - 2) Any cause of shortened erythrocyte survival or decreased mean erythrocyte survival or decreased mean erythrocyte age eg. hemolytic diseases, pregnancy, significant recent/chronic blood loss etc. will reduce exposure of RBC to glucose with consequent decrease in HbA1c values.
  - 3) Glycated HbF is not detected by this assay and hence specimens containing high HbF ( $>10\%$ ) may result in lower HbA1c values than expected. Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus
- HbA1C, also known as glycated hemoglobin, is the most important test for the assessment of long term blood glucose control (also called glycemic control).
- HbA1C reflects mean glucose concentration over past 6-8 weeks and provides a much better indication of longterm glycemic control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.
- Glycemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD ) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP)

Note : Biological reference intervals are according to American Diabetes Association (ADA) Guidelines.

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Patient Data

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 Patient ID: 151000722587  
 Name: SAISH UMESH PATIL  
 Physician: M  
 Sex: M  
 DOB:

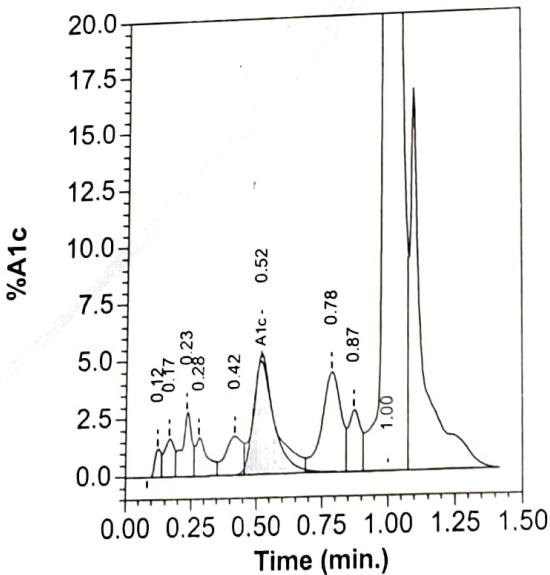
Analysis Data

Analysis Performed: 20/OCT/2025 09:45:56  
 Injection Number: 7170  
 Run Number: 220  
 Rack ID: 3  
 Tube Number: 20/OCT/2025 09:48:16  
 Report Generated: Operator ID:

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
Unknown	---	0.3	0.122	3430
A1a	---	0.7	0.165	7452
A1b	---	1.1	0.232	12171
F	---	0.8	0.280	9085
LA1c	---	1.0	0.418	11223
A1c	4.9	---	0.517	46046
P3	---	3.4	0.785	36460
P4	---	1.3	0.870	14399
Ao	---	87.1	1.000	945028

Total Area: 1,085,294

HbA1c (NGSP) = 4.9 %



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 Email: unipathlab.surat@gmail.com  
 Out source Lab USLL Ahmedabad :Unipath House, Beside Sahjanand college, Opposite Kamdeno Complex, Panjarapole, Ambawadi, Ahmedabad-380015  
 Unigenome: 2A,3A,3B PASL -House, Beside Sahjanand college, Opposite Kamdeno Complex, Panjarapole, Ambawadi, Ahmedabad-380015,Gujarat  
 Phone: 07699991171 | Email: info@unipath.in | Website: www.unipath.in

## TEST REPORT

	Reg. No. : 51000722587 Reg. Date : 20-Oct-2025 06:14 Ref.No. :	Approved On : 20-Oct-2025 09:31
Name : Mr. SAISH UMESH PATIL	Collected On : 20-Oct-2025 06:14	
Age : 22 Years Gender: Male Pass. No. :	Dispatch At :	
Ref. By : Dr. SAVITA PATIL M.B.B.S (GYNEC)	Tele No. :	
Location : ATHARV CLINICAL LABORATORY @ SHIRPUR		

Test Name	Results	Units	Bio. Ref. Interval
<b>FASTING PLASMA GLUCOSE</b>			
<u>Specimen: Fluoride plasma</u>			
Fasting Plasma Glucose	95.82	mg/dL	Normal: <=99.0 Prediabetes: 100-125 Diabetes :>=126
Method: Hexokinase	Nil		Nil
Urine Glucose -F Strip Test (God Pod)	Nil		
Urine Acetone -F	Nil		Negative
Sample Type:Flouride Plasma	97.12	µg/dL	59 - 158
Iron (Fe)			
Method: Ferrozine			
Sample Type: Serum			
Decreases in iron-deficiency anaemia, chronic infection, carcinoma, chronic renal failure, hypothyroidism, postoperative state, kwashiorkor.			
Increased in Hemochromatosis, hemosiderosis.			
Criteria for the diagnosis of diabetes:			
1. HbA1c >/= 6.5 *			
Or			
2. Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.			
Or			
3. Two hour plasma glucose >/= 200mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water.			
Or			
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >/= 200 mg/dL. *In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34:S11.			

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Test done from collected sample.

Dr. Brijesh Patel  
 M.D. Pathology  
 Reg. No.: G-32437

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## TEST REPORT

Reg. No. : 51000722587 Reg. Date : 20-Oct-2025 06:14 Ref. No. :  
Name : Mr. SAISH UMESH PATIL  
Age : 22 Years Gender: Male Pass. No. :  
Ref. By : Dr. SAVITA PATIL M.B.B.S (GYNEC)  
Location : ATHARV CLINICAL LABORATORY @ SHIRPUR

Approved On : 20-Oct-2025 11:12  
Collected On : 20-Oct-2025 06:14  
Dispatch At :  
Tele No. :

Test Name	Results	Units	Bio. Ref. Interval
Calcium	9.5	mg/dL	8.6 - 10.0
SAPTA			
Immunoassay	17.1	ng/mL	Deficiency : <10 Insufficiency : 10 - 30 Sufficiency : 30 - 100 Toxicity : >100
Vitamin D			

### Method: CLIA

Vitamin D is a fat soluble hormone involved in the intestinal absorption and deregulation of calcium. It is synthesized by skin when sunlight strikes bare skin. It can also be ingested from animal sources. Vitamin D is bound to the binding protein (albumin and vitamin D binding protein) and carried to the liver. In the liver it is transformed in to 25 hydroxy-vitamin D (calcidiol), which is the primary circulating and the most commonly measured form in serum. Then in the kidney it is transformed in to 1,25 dihydroxy-vitamin D (calcitriol), which is the biologically active form. Vitamin D plays a vital role in the formation and maintenance of strong and healthy bones. Vitamin D deficiency has long been associated with rickets in children and osteomalacia in adults. Long term insufficiency of calcium and vitamin D leads to osteoporosis. There have been multiple publications linking vitamin D deficiency to several disease states, such as cancer, cardiovascular disease, diabetes, and autoimmune diseases.

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Dhaval

Brijesha

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Dr. Dhaval Bamania  
Pathologist  
G-16880

Dr. Brijesha Patel  
M.D. Pathology  
Reg. No.: G-32437

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**NOME**  
Division of USLL



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Unigenome: 2A,3A,3B PASL -House, Beside Sahjanand college, Opposite Kamdenu Complex, Panjarapole, Ambawadi, Ahmedabad-380015,Gujarat  
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## TEST REPORT



Reg. No. : 51000722587 Reg. Date : 20-Oct-2025 06:14 Ref. No. : Approved On : 20-Oct-2025 11:12  
Name : Mr. SAISH UMESH PATIL Collected On : 20-Oct-2025 06:14  
Age : 22 Years Gender: Male Pass. No. : Dispatch At :  
Ref. By : Dr. SAVITA PATIL M.B.B.S (GYNEC) Tele No. :  
Location : ATHARV CLINICAL LABORATORY @ SHIRPUR

### Immunoassay

324

pg/mL

211 - 911

### Vitamin B12

Method: CLIA

Sample Type: Serum

#### INTERPRETATION

Dietary sources of Vitamin B12 are meat, eggs, milk and milk products. Vitamin B12 requires intrinsic factor for absorption from intestine. B12 deficiency causes hematological and neurological abnormalities. Decreased serum B12 levels causes increased excretion of methylmalonic acid. The impaired DNA synthesis associated with Vitamin B12 deficiency causes macrocytic anemias. In sever is characterized by abnormal maturation of erythrocyte, myeloid precursors and megakaryocytes in the bone marrow, which results in the pancytopenia. Withhold Vitamin B12 injection before the blood is drawn. Blood collected after Vitamin B12 Injection interfere with result. Preservatives such as fluorides & ascorbic acid interfere with this assay. Excessive exposure of the specimen to light may alter Vitamin B12 result.

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*Dhaval*

*Brijesha*

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Dr. Dhaval Bamania  
Pathologist  
G-16880

Dr. Brijesha Patel  
M.D. Pathology  
Reg. No.: G-32437



## TEST REPORT

Reg. No.	51000722587	Reg. Date	20-Oct-2025 06:14	Ref.No:	Approved On	: 20-Oct-2025 11:55
Name	Mr. SAISH UMESH PATIL				Collected On	: 20-Oct-2025 06:14
Age	22 Years	Gender:	Male	Pass. No.:	Dispatch At	:
Ref. By	Dr. SAVITA PATIL M.B.B.S (GYNEC)				Tele No.	:
Location	ATHARV CLINICAL LABORATORY @ SHIRPUR					

Test Name	Results	Units	Bio. Ref. Interval
<b>Physical Examination</b>			
Quantity	20	mL	
Colour	Yellow		
Clarity	Clear		
<b>CHEMICAL EXAMINATION (by strip test)</b>			
pH (Methyl Red & Bromothymol Blue)	6.0		4.6 - 8.0
Sp. Gravity (Sodium Hydroxide)	1.010		1.002 - 1.030
Protein (Tetrabromophenol Blue)	Absent		Absent
Glucose (By GOD POD)	Absent		Absent
Ketone (Sodium Nitropruside)	Absent		Absent
Bilirubin (Diachloroanilinediazonium)	Absent		Nil
Nitrite (Tetrahydrobenzoquinolinol)	Absent		Nil
Leucocytes (By Leuco.esterase)	Nil		Nil
Blood (Tetramethylbenzidine)	Nil		Absent
<b>MICROSCOPIC EXAMINATION</b>			
Leucocytes (Pus Cells)	Occasional/hpf		0 - 5/hpf
Erythrocytes (RBC)	Nil	/hpf	0 - 5/hpf
Casts	Nil		Absent
Crystals	Nil		Absent
Epithelial Cells	1 - 2/hpf		Nil
Monilia	Absent		Nil
T. vaginalis	Absent		Nil
Bacteria	Absent		Absent
Sample Type: Urine			

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Pathologist  
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Ref. By	Dr. SAVITA PATIL M.B.B.S (GYNEC)					Tele No.	:
Location	ATHARV CLINICAL LABORATORY @ SHIRPUR						

Test Name	Results	Units	Bio. Ref. Interval
Iron (Fe)	97.12	µg/dL	59 - 158

Method:Ferrozine

Sample Type:Serum

Decreases in iron-deficiency anaemia, chronic infection, carcinoma, chronic renal failure, hypothyroidism, postoperative state, kwashiorkor. Increased in Hemochromatosis,hemosiderosis.

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

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*Brijesha*

Dr. Brijesha Patel  
M.D. Pathology  
Reg. No.: G-32437

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