Patient Ref. No. 707000000336979

**CLIENT CODE :** CR00000044

**CLIENT'S NAME AND ADDRESS :**
SRL REACH LTD OPD PATIENTS
SADAR HOSPITAL, BOKORO, SECTOR - 1, BOKORO STEEL CITY,

BOKARO 827001
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Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
BOKORO, 827001
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Tel : 7260813496
Email : customercare.bokaro@agilus.in

**PATIENT NAME : BABLU PRASAD** PATIENT ID : **BABLM281082707**

ACCESSIO NO : **0707WG001203** AGE : 40 Years SEX : Male

DRAWN : 19/07/2023 09:52 RECEIVED : 19/07/2023 09:54 REPORTED : 19/07/2023 18:13

**REFERRING DOCTOR :** DR. SADAR HOSPITAL CLIENT PATIENT ID :

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|

## HAEMATOLOGY

### CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

| | | | | |
|---|---|---|---|---|
| **BLOOD COUNTS,EDTA WHOLE BLOOD** | | | | |
| HEMOGLOBIN (HB) | **6.2** | **Low** | 13.0 - 17.0 | g/dL |
| RED BLOOD CELL (RBC) COUNT | **2.06** | **Low** | 4.5 - 5.5 | mil/µL |
| WHITE BLOOD CELL (WBC) COUNT | **3.2** | **Low** | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT | **117** | **Low** | 150 - 410 | thou/µL |
| **RBC AND PLATELET INDICES** | | | | |
| HEMATOCRIT (PCV) | **18.0** | **Low** | 40 - 50 | % |
| MEAN CORPUSCULAR VOLUME (MCV) | 87.0 | | 83 - 101 | fL |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) | 30.1 | | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) | 34.4 | | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH (RDW) | **16.6** | **High** | 11.6 - 14.0 | % |
| MENTZER INDEX | 42.2 | | | |
| MEAN PLATELET VOLUME (MPV) | 8.6 | | 6.8 - 10.9 | fL |
| **WBC DIFFERENTIAL COUNT** | | | | |
| NEUTROPHILS | 52 | | 40 - 80 | % |
| LYMPHOCYTES | 40 | | 20 - 40 | % |
| MONOCYTES | 05 | | 2 - 10 | % |
| EOSINOPHILS | 03 | | 1 - 6 | % |
| BASOPHILS | 0 | | < 1 - 2 | % |
| ABSOLUTE NEUTROPHIL COUNT | **1.66** | **Low** | 2.0 - 7.0 | thou/µL |
| ABSOLUTE LYMPHOCYTE COUNT | 1.28 | | 1.0 - 3.0 | thou/µL |
| ABSOLUTE MONOCYTE COUNT | **0.16** | **Low** | 0.2 - 1.0 | thou/µL |
| ABSOLUTE EOSINOPHIL COUNT | 0.10 | | 0.02 - 0.50 | thou/µL |
| ABSOLUTE BASOPHIL COUNT | **0** | **Low** | 0.02 - 0.10 | thou/µL |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 1.3 | | | |
| **ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD** | | | | |
| E.S.R | **134** | **High** | 0 - 14 | mm at 1 hr |

**Interpretation(s)**
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.



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**PATIENT NAME : BABLU PRASAD** PATIENT ID : **BABLM281082707**

ACCESSION NO : **0707WG001203** AGE : 40 Years SEX : Male

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RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
**TEST INTERPRETATION**
**Increase** in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
**Decreased** in: Polycythermia vera, Sickle cell anemia

**LIMITATIONS**
**False elevated** ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
**False Decreased** : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

## BIO CHEMISTRY

### LIVER FUNCTION PROFILE, SERUM

| | | | | |
|---|---|---|---|---|
| BILIRUBIN, TOTAL | 0.60 | | 0.0 - 2.0 | mg/dL |
| BILIRUBIN, DIRECT | **0.30** | **High** | < 0.2 | mg/dL |
| BILIRUBIN, INDIRECT | 0.30 | | 0.1 - 1.0 | mg/dL |
| TOTAL PROTEIN | **6.2** | **Low** | 6.4 - 8.3 | g/dL |
| ALBUMIN | **3.2** | **Low** | 3.5 - 5.2 | g/dL |
| GLOBULIN | 3.0 | | 2.3 - 3.5 | g/dL |
| ALBUMIN/GLOBULIN RATIO | 1.1 | | 1.0 - 2.1 | RATIO |
| ASPARTATE AMINOTRANSFERASE(AST/SGOT) | 22 | | 0.0 - 35.0 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT) | 21 | | 0.0 - 45.0 | U/L |
| ALKALINE PHOSPHATASE | 125 | | 53 - 128 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT) | 25 | | 0.0 - 55.0 | U/L |
| LACTATE DEHYDROGENASE | **454** | **High** | 225 - 450 | U/L |

### KIDNEY FUNCTION TEST



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Patient Ref. No. 707000000336979

**CLIENT CODE :** CR00000044

**CLIENT'S NAME AND ADDRESS :**
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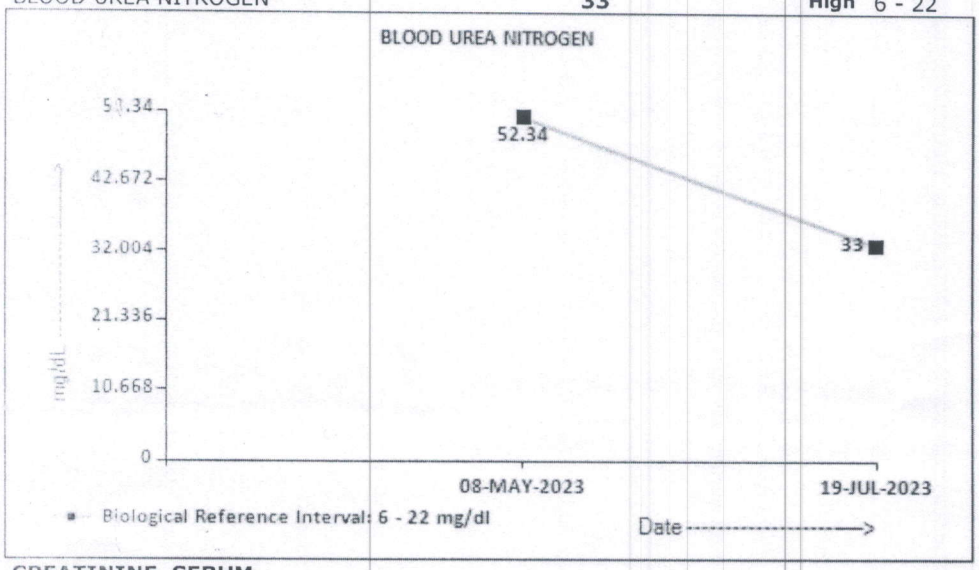
**PATIENT NAME : BABLU PRASAD** PATIENT ID : **BABLM281082707**

ACCESSION NO : **0707WG001203** AGE : 40 Years SEX : Male

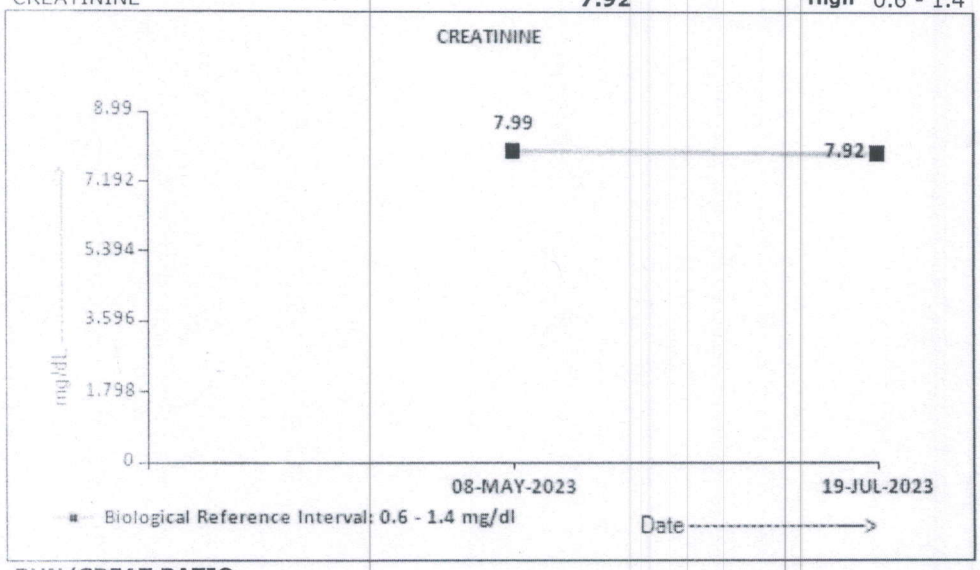
DRAWN : 19/07/2023 09:52 RECEIVED : 19/07/2023 09:54 REPORTED : 19/07/2023 18:13

**REFERRING DOCTOR :** DR. SADAR HOSPITAL CLIENT PATIENT ID :

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| **BLOOD UREA NITROGEN (BUN), SERUM** | | | |
| BLOOD UREA NITROGEN | **33** | **High** 6 - 22 | mg/dL |




| | | | |
|---|---|---|---|
| **CREATININE, SERUM** | | | |
| CREATININE | **7.92** | **High** 0.6 - 1.4 | mg/dL |




| | | | |
|---|---|---|---|
| **BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO | **4.17** | **Low** 5.0 - 15.0 | |



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**PATIENT NAME : BABLU PRASAD** PATIENT ID : **BABLM281082707**

ACCESSION NO : **0707WG00120** AGE : 40 Years SEX : Male

DRAWN : 19/07/2023 09:52 RECEIVED : 19/07/2023 09:54 REPORTED : 19/07/2023 18:13

**REFERRING DOCTOR :** DR. SADAR HOSPITAL CLIENT PATIENT ID :

| Test Report Status **Final** | Results | | Biological Reference Interval | Units |
|---|---|---|---|---|
| **URIC ACID, SERUM** | | | | |
| URIC ACID | 4.9 | | 3.5 - 7.2 | mg/dL |
| **TOTAL PROTEIN, SERUM** | | | | |
| TOTAL PROTEIN | **6.2** | **Low** | 6.4 - 8.3 | g/dL |
| **ALBUMIN, SERUM** | | | | |
| ALBUMIN | **3.2** | **Low** | 3.5 - 5.2 | g/dL |
| **GLOBULIN** | | | | |
| GLOBULIN | 3.0 | | 2.3 - 3.5 | g/dL |
| **CALCIUM, SERUM** | | | | |
| CALCIUM | **7.7** | **Low** | 8.6 - 10.2 | mg/dL |

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
**Bilirubin** is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
**AST** is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
**ALP** is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.
**GGT** is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
**Total Protein** also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
**Albumin** is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
**Causes of decreased** level include Liver disease, SIADH.
CREATININE, SERUM-**Higher than normal level may be due to:**
• Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)
**Lower than normal level may be due to:**• Myasthenia Gravis, Muscuophy
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
**Higher-than-normal levels may be due to:** Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
**Lower-than-normal levels may be due to:** Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.



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CLIENT CODE : CR00000044

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PATIENT NAME : **BABLU PRASAD**

PATIENT ID : **BABLM281082707**

ACCESSION NO : **0707WG001203** AGE : 40 Years SEX : Male

DRAWN : 19/07/2023 09:52 RECEIVED : 19/07/2023 09:54 REPORTED : 19/07/2023 18:13

REFERRING DOCTOR : DR. SADAR HOSPITAL CLIENT PATIENT ID :

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CALCIUM, SERUM-**Common causes of decreased value of calcium (hypocalcemia)** are chronic renal failure, hypomagnesemia and hypoalbuminemia. **Hypercalcemia (increased value of calcium)** can be caused by increased intestinal absorption (vitamin D intoxication), increased skeletal reabsorption (immobilization), or a combination of mechanisms (primary hyperparathyroidism). Primary hyperparathyroidism and malignancy accounts for 90-95% of all cases of hypercalcemia. Values of total calcium is affected by serum proteins, particularly albumin thus, latter's value should be taken into account when interpreting serum calcium levels. The following regression equation may be helpful.
Corrected total calcium (mg/dl)= total calcium (mg/dl) + 0.8 (4- albumin [g/dl])*
because regression equations vary among group of patients in different physiological and pathological conditions, mathematical corrections are only approximations. The possible mathematical corrections should be replaced by direct determination of free calcium by ISE (available with srl) a common and important source of preanalytical error in the measurement of calcium is prolonged torniquet application during sampling. Thus, this along with fist clenching should be avoided before phlebotomy.

## EIA - INFECTIOUS SECTION

### HEPATITIS B SURFACE ANTIGEN, SERUM

| | | |
|---|---|---|
| HEPATITIS B SURFACE ANTIGEN | NON REACTIVE | NON REACTIVE |

### HEPATITIS C ANTIBODIES, SERUM

| | | |
|---|---|---|
| HEPATITIS C ANTIBODIES | NON REACTIVE | NON REACTIVE |

**Interpretation(s)**
HEPATITIS B SURFACE ANTIGEN, SERUM-**Hepatitis B** is caused by infection with HBV, a enveloped DNA agent that is classified as hepadnavirus. This test detects the presence of viral surface antigen i.e HBsAg also known as "Australia antigen" in serum sample and is indicative of HBV infection, either acute or chronic.
**Test Utility:** HBsAg is the first serologic marker appearing in the serum 6-16 weeks following hepatitis B viral infection. In typical HBV infection, HBsAg will be detected 2-4 weeks before the liver enzyme levels (ALT) become abnormal and 3-5 weeks before patient develops jaundice. In acute cases HBsAg usually disappears 1-2 months after the onset of symptoms. Persistence of HBsAg for more than 6 months indicates development of either a chronic carrier state or chronic liver disease.The presence of HBsAg is frequently associated with infectivity. HBsAg when accompanied by Hepatitis Be antigen and/or hepatitis B viral DNA almost always indicates infectivity.
**Limitations:** For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute or chronic infection. If the antibody results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.HBsAg detection will only indicate the presence of surface antigens in the serum and should not be used as the sole criteria for diagnosis, staging or monitoring of HBV infection. This test may be negative during "window period" i.e. after disappearance of anti-HBsAg antibody.The current assay being a highly sensitive test may yield a small percentage of false positive reports. Hence all HBsAg positive specimens should be confirmed with an assay based upon Neutralisation of Human anti Hepatitis B Surface antibody.
HEPATITIS C ANTIBODIES, SERUM-**Hepatitis C Virus (HCV)** is a blood borne flavivirus. It is one of the most important causes of post-blood transfusion as well as community acquired non-A non-B hepatitis and chronic liver failure. Although the majority of infected individuals may be asymptomatic, HCV infection may develop into chronic hepatitis, cirrhosis and/or increased risk of hepatocellular carcinoma.
**Notes & Limitations:** HCV antibody is typically not detected until approximately 14 weeks after infection (or 5 weeks after appearance of the first biochemical marker of illness) and is almost always detectable by the late convalescent stage of infection. A negative result may also be observed due to loss of HCV antigen, years following resolution of infection. Infants born to hepatitis C infected mothers may have delayed seroconversion to anti-HCV. Hence a negative result should be evaluated cautiously with respect to clinical findings. It is to be noted that absence of HCV antibodies after 14 weeks of exposure is strong evidence against HCV infection.Presence of HCV antibodies does not imply an active Hepatitis C infection but is indicative of both past and/or recent infection .It has been reported that as many as 90% of individuals receiving intravenous commercial immunoglobulin test falsely positive for HCV antibody. Also,patients with autoimmune liver disease may show a false positive HCV antibody result. Hence it is advisable to confirm a positive antibody result with a supplemental test. A positive result when followed by a positive supplemental test (i.e. HCV-RNA-PCR) suggests active hepatitis C infection.

****End Of Report****
**Please visit www.srlworld.com for related Test Information for this accession**

Dr. Aakash, MD,Path
Consultant Pathologist

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Patient Ref. No. 31000004755877

Cert. No. M-0086

CLIENT CODE : CR00000044

CLIENT'S NAME AND ADDRESS :
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Tel : 033-30203421 / 033-30203400, Fax : 30203412
CIN - U74899DL1995PLC070603

PATIENT NAME : **BABLU PRASAD**

PATIENT ID : **BABLM20078331**

ACCESSION NO : **0031WG01692**

AGE : 40 Years SEX : Male

DRAWN : 19/07/2023 00:00 RECEIVED : 20/07/2023 12:41 REPORTED : 20/07/2023 15:34

REFERRING DOCTOR : DR. SADAR HOSPITAL

CLIENT PATIENT ID :

CLINICAL INFORMATION :

0707WG001203

| Test Report Status Final | Results | Biological Reference Interval | Units |
|---|---|---|---|
| **BIO CHEMISTRY** | | | |
| IRON, SERUM | | | |
| IRON<br>METHOD : FERENE | 86 | 65 - 175 | µg/dL |

Interpretation(s)
IRON, SERUM-Serum iron test is useful for etio- morphological diagnosis of anemias, in hemochromatosis, in hemosiderosis and in acute iron toxicity. Serum iron is recommended to be correlated with Total Iron Binding Capacity (TIBC) for evaluation of iron deficiency.

****End Of Report****

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Dr. Chaitali Ray, PHD
Biochemist



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Patient Ref. No. 31000004755902

Cert. No. M-0086

CLIENT CODE : CR00000048

CLIENT'S NAME AND ADDRESS :
KIT DOWN SADAR HOSPITAL, BOKORO
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Tel : 033-30203421 / 033-30203400, Fax : 30203412
CIN - U74899DL1995PLC070603

PATIENT NAME : **BABLU PRASAD**

PATIENT ID : **BABLM20078331A**

ACCESSION NO : **0031WG01695**

AGE : 40 Years SEX : Male

DRAWN :

RECEIVED : 20/07/2023 12:53

REPORTED : 20/07/2023 17:57

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

CLIENT PATIENT ID :

0707WG001203

| Test Report Status **Final** | Results | | Biological Reference Interval | Units |
|---|---|---|---|---|
| **BIO CHEMISTRY** | | | | |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | | |
| SODIUM, SERUM | 138 | | 136 - 145 | mmol/L |
| METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT | | | | |
| POTASSIUM, SERUM | 4.40 | | 3.5 - 5.1 | mmol/L |
| METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT | | | | |
| CHLORIDE, SERUM | **108** | High | 98 - 107 | mmol/L |
| METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT | | | | |

**End Of Report**

**Please visit www.srlworld.com for related Test Information for this accession**

Dr. Chaitali Ray, PHD
Biochemist

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