

RAHASIA



PT. Inspektindo Sinergi Persada

HEALTH AND MEDICAL CHECK UP

No. 0094/M5U-SHBP/VIII/2018

Nama : Dhian Arditama, Tn
Tanggal Lahir : 07 November 1979
Jenis Kelamin : Male
S/N :
Jabatan / Posisi : Inspector

Tanggal MCU : 20 Agustus 2018

Dilakukan oleh : dr. Linda Uli Natalisa
dr. Santoso Suhendro, SP. Rad
dr. M. Iqbal, Sp. JP
dr. Diah Adhyaksanti, Sp. P
dr. Maranatha L. B, Sp. THT – KL

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RAHASIA

HEALTH AND MEDICAL CHECK UP

No. 0094/M5U-SHBP/III/2018

Kepada : Dhian Arditama, Tn Umur/ Tanggal 39 tahun 07 Nov 1979 Male
Dept : PT. Inspektindo Sinergi Persada

Berikut adalah hasil pemeriksaan Medical Check Up yang telah dilaksanakan pada tanggal **20 August 2018**

- TEMUAN**
1. BMI : 29,32 kg/m (Overweight).
 2. Gigi : Calculus, caries.
 3. Spirometri : Restriksi ringan.
 4. Laboratorium DL : GDP meningkat.

STATUS

CATEGORY	NOTE
1A	Fit, tidak dijumpai problem kesehatan
1B	Fit, dijumpai problem kesehatan yang tidak serius
2	Fit, dengan problem kesehatan yang dapat menjadi serius - Kelompok resiko rendah
3A	Dengan problem kesehatan yang dapat menjadi serius - Kelompok resiko sedang
3B	Dengan problem kesehatan yang dapat menjadi serius - Kelompok resiko tinggi
4	Unfit, dengan keterbatasan fisik untuk melakukan pekerjaan secara normal, hanya cocok untuk pekerjaan ringan
5	Unfit, sedang sakit, perawatan rumah sakit atau dalam kondisi yang tidak memungkinkan untuk melakukan pekerjaan (status ijin sakit)

KESIMPULAN

FIT

sebagai Inspector di Lokasi Kerja PT. Inspektindo Sinergi Persada

SARAN

1. Menjaga kebersihan gigi dan mulut, kontrol ke Dokter Gigi untuk perawatan.
2. Turunkan berat badan dengan cara rutin berolahraga.
3. Hindari makanan tinggi gula dan tinggi karbohidrat.

Berlaku : **20 August 2019**

Bila masih ada hal yang perlu diperjelas, mohon segera menghubungi Dokter Pemeriksa. Terimakasih atas kerjasamanya

Dokter Pemeriksa,



dr. Linda Uli Natalisa

Medical Department

HEALTH AND MEDICAL CHECK UP

PHYSICAL EXAMINATION

Name	Dhian Arditama, Tn	S/N		DEPT	Inspektindo Sinergi Persa
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I. GENERAL CONDITION

Blood Pressure (mmHg)	110/80	Pulse (x/mnt)	70	Respiration (x/mnt)	20	Temp (°C)	36,0
Weight (kg)	76	Height (cm)	161	BMI (kg/m ²)	29.32	Waist (cm)	101

* BMI = W / H² (Underweight = < 18-25, Overweight 25-30, Obese >30)

II. PHYSICAL

No	PHYSICAL	A = ABNORMAL N = NORMAL	A	N	Describe abnormalities in detail
					(circle words of importance and explain)
1	GENERAL APPEARANCE	Appearance age/nutritional/development/mental & emotional status/Posture/Gait/Speech		N	-
2	HEAD/SCALP	Size/Shape/Tender over sinuses/Hair/Eruption		N	-
3	EYES	Conjunctiva/Sclera/Cornea/Pupils/Ptosis/Tension/Eyelid/Bruit/Reflex/Range of Movement		N	-
4	EARS	Ext. canal/Membran perforation/Discharge/tophi/Hearing problem/Mastoids		N	-
5	NOSE/SINUSES	Septum/obstruction/turbinates/discharges		N	-
6	MOUTH/THROAT	Odor/Lips/Tongue/Tonsils/Gums/Pharynx		N	-
7	TEETH	Caries ☉, filling (F), Missing (M), Radix ☉	A		Calculus, caries
8	NECK	Adenopathi/Thyroid/Carotids/Trachea/Veins/Mass/Spine/Motion/Bruit		N	-
9	BACK/SPINE	Kyphosis/Scoliosis/Lordosis/mobility/CVA/Bone/Tenderness/other deformities		N	-
10	THORAX	Symmetry/movement/countour/tender		N	-
11	BREAST	Size/cosistency/Nipples/areolar/discharge/palpable mass/tenderness/nodes/scars		N	-
12	HEART	Rate/rhythm/apical/impulse/Trills/quality of sound/intensity/splitting/extra sound/murmurs		N	-
13	CHEST / LUNG	Excursion/dullness or hyper - resonance of percussion/Quality of breath sound/rales/whezzing/ronchi/bruit		N	-
14	ABDOMEN	Bowel sounds/appearance/liver/spleen/masses/Hemias,murmur/countour/tenderness/bruit/nodes		N	-
15	GROIN	Hemia/inguinal nodes/femoral pulses		N	-
16	MALE GENITAL	Penis/testis/scrotum epididymis/varicocele/scars/Discharge/circumcised/piercing		N	-
17	FEMALE GENITAL	Vulva/vagina/Cervix/Uterus/adnexae/rectoccle/Bartholini gland/urethra/discharge			-
18	EXTREMITIES	Deformity/clubbing/cyanosis/edema/nail/periperal pulses/calf tenderness/joints for swelling/ROM		N	-
19	JOINTS	ROMS/swelling/inflamation/Deformity		N	-
20	SKIN	Color/birthmark/scars/tatoos/texture/rash/eczeme/ulcers/piercing		N	-
21	NEUROLOGICAL	Reflexes/cranial nerve/tremor/paralysis/motoric/sensoric(touch,prick,vibrate)/coordination/romberg		N	-
22	MUSCULAR SYSTEM	Strength/wasting/development		N	-
23	RECTAL EXAM	Sphincter tone/hemorrhoids/fissure/masses/prostate		N	-

SUPPORTIVE INVESTIGATIONS

Name

Dhian Arditama, Tn

I. VISION

Vision	Unaided		With spectacles		Night	Colour Blindness
	Left	Right	Left	Right		
Distant	6/6	6/6	-	-		<input checked="" type="checkbox"/> Normal
Near	20/20	20/20	-	-		<input type="checkbox"/> Red - Green Absent
Visual fields (normal > 70°)			Left	-		<input type="checkbox"/> Colour Blind
COMMENT :						

II. LABORATORIUM SUMMARY

<input type="checkbox"/> Normal	COMMENT :	Laboratorium DL : GDP meningkat.
<input checked="" type="checkbox"/> Abnormal		

III. CHEST X-RAY

Pneumoconiosis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If Yes - ILO Classification	-	
Evidence of TB	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other Abnormalities	-	
COMMENT :		

IV. ECG (Optional for over 35 years of age)

See attached result

<input checked="" type="checkbox"/> Normal	COMMENT :	Normal sinus rhythm
<input type="checkbox"/> Abnormal		

V. TREADMILL (Optional for over 40 years of age)

See attached result

<input checked="" type="checkbox"/> Normal	COMMENT :	Response ischemic negative
<input type="checkbox"/> Abnormal		

VI. SPIROMETRY (Optional for dust exposure, respiratory chronic disease,...)

Test	Predicted	Observed	Percentage
VC	4	-	- %
FVC	4	3	76 %
FEV1	3	3	80 %
FEV/FVC	80	90	111 %
COMMENT :		Restriksi ringan	

VII. AUDIOMETRY (Optional for noise exposure, previous hearing problem)

See attached result

CONCLUSION	Change since last audiometric examination	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> Normal	If Yes, what change :	-	
<input type="checkbox"/> Abnormal	Recommended action :	-	
Refer to safety department :		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

VIII. USG

COMMENT :	Dalam batas normal
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MCU

Medical Check Up

No. Rekam Medis : _____
Nama : Dhian Arditama
Perusahaan : PT. Inspektindo Sinergi Persada
Jabatan / Posisi : Inspector
Tanggal MCU : 20 August 2018

KEBIASAAN MEROKOK

01. Apakah Anda pernah merokok ? 1. Ya 2. Tidak 1
bila tidak langsung ke alkohol
02. Sejak umur berapa Anda mulai merokok untuk pertama kalinya ?
03. Apakah saat ini anda merokok ? 1. Ya, setiap hari 3
2. Ya, tidak setiap hari
3. Tidak - *bila tidak langsung ke no. 12*
04. Berapa banyak rokok yang Anda isap setiap harinya ?
05. Jenis rokok apa yang Anda isap ? (DITULIS MEREK) 1. Kadar nikotin rendah
2. Kadar nikotin sedang
3. Kadar nikotin tinggi
06. Seberapa sering anda menghisap dalam-dalam asap rokok ? 1. Tidak pernah
2. Kadang-kadang
3. Selalu
07. Berapa menit sehabis bangun tidur Anda mulai merokok ?
08. Apakah anda lebih banyak merokok dalam 2 jam pertama di pagi hari ? 1. Ya 2. Tidak
09. Apakah sulit untuk tidak merokok di tempat yang di larang merokok ? 1. Ya 2. Tidak
10. Apakah anda tetap merokok di saat anda sedang sakit ? 1. Ya 2. Tidak
11. Dalam satu hari rokok manakah yang sulit di lewatkan ? *Dari no. 11 langsung ke pertanyaan alkohol* 1. Rokok pertama di pagi
2. Rokok lainnya
12. Sudah berapa lama Anda berhenti merokok ? (tahun)

KONSUMSI ALKOHOL

01. Apakah Anda pernah minum minuman beralkohol ? 1. Ya 2. Tidak 1
bila tidak langsung ke olahraga
02. Apakah Anda minum minuman beralkohol dalam 12 bulan terakhir ? 1. Ya 2. Tidak 2
bila tidak langsung ke olahraga
03. Apakah Anda minum minuman beralkohol dalam 4 minggu terakhir ? 1. Ya 2. Tidak
bila tidak langsung ke olahraga
04. Berapa kali anda minum minuman beralkohol dalam sebulan ?
05. Berapa banyak minuman beralkohol yang Anda habiskan tiap kalinya ? (diperkirakan dim satuan cc)

03. Berapa jumlah kehamilan yang pernah dialami (termasuk kehamilan saat ini) ?

04. Berapa jumlah keguguran yang pernah dialami ?

05. Kapan hari pertama haid terakhir Anda ? / /

06. Berapa umur Anda pada saat haid pertama ?

07. Berapa banyak darah pada saat Anda haid ? 1. Banyak 2. Sedikit

08. Apakah dalam satu tahun terakhir pola haid Anda teratur ? 1. Ya 2. Tidak

09. Apakah ada rasa sakit yang berhubungan dengan haid ? 1. Ya 2. Tidak

10. Apakah Anda sering menderita keputihan ? 1. Ya 2. Tidak

KELUARGA BERENCANA

01. Apakah keluarga Anda mengikuti Keluarga Berencana ? 1. Ya 2. Tidak
bila tidak langsung ke vaksinasi

02. Bila YA, metode KB apa Anda gunakan ? 1. Kondom 5. IUD
2. Pil 6. Vaksetomi
3. Suntik 7. Tubektomi
4. Susuk 8. Lainnya

RIWAYAT VAKSINASI

01. Apakah Anda pernah mendapatkan vaksinasi Tetanus ? 1. Ya 3. Tidak tahu
2. Tidak

02. Apakah Anda pernah mendapatkan vaksinasi Hepatitis ? 1. Ya 3. Tidak tahu
2. Tidak

DONOR DARAH

01. Bersediakah Anda mendonorkan darah bila diperlukan ? 1. Ya 2. Tidak

02. Kapan Anda melakukan donor darah terakhir ? / /

Formulir tersebut diatas telah saya isi dengan benar dan sesungguhnya

Balikpapan, 20 August 2018
Nama dan tanda tangan karyawan


(Dhian Anditama)

NAME

12/JUL/2018 AM 10:55



		mmHg		AVG
R	14	14	13	14
L	14	14	13	14

CT-80 TOPCON

SH <input type="text"/>	MR :035199
FORMULIR PEMERIKSAAN MATA EYE EXAMINATION FORM	Name : DHIAN ARDITAN
	Sex : M
	DoB : 1979/11/07
	Ward : Out Patient

OD / RE

OS / LE



Mata Kanan (Right Eye)	Parameter	Mata Kiri (Left Eye)
9/6	Visus (Visual acuity)	9/6
-	Koreksi (Correction)	-
20/20	Adisi (Addition)	20/20
	Gerakan Bola Mata (Eye movement)	
	Kesegaran (Alignment)	
	Kelopak Mata (Eyelid)	
	Konjungtiva (Conjunctiva)	
	Kornea (Cornea)	
Normal	Bilik Mata Depan (COA)	Normal
	Pupil	
	Iris	
	Lensa (Lens)	
	Vitreous	
	Fundus	
4	TIO	4
	Lapang Pandang (Visual field)	
	Persepsi Warna (Color perception)	

Kesimpulan OPS. Embryoni

BPN 20/8/2018

 Nama dokter & tanda tangan
 Doctor's name & signature

SH HASIL PEMERIKSAAN AUDIOMETRI AUDIOMETRY REPORT	MR : 035199 Name : DHIAN ARDITAMA, TN Sex : M DoB : 1979/11/07 Ward : Out Patient
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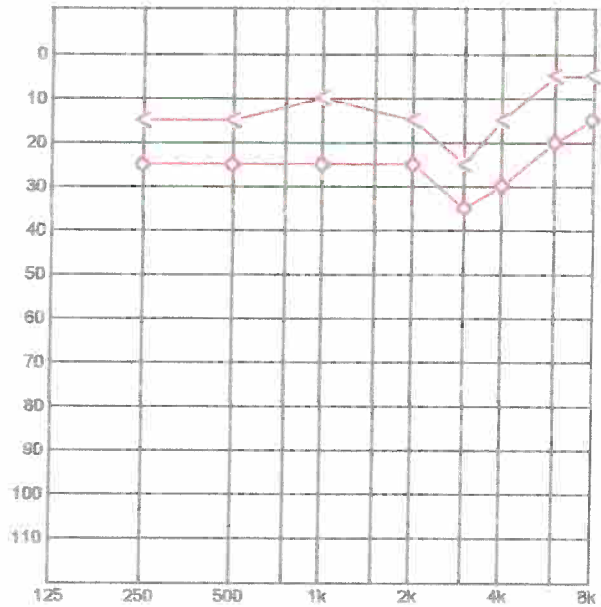
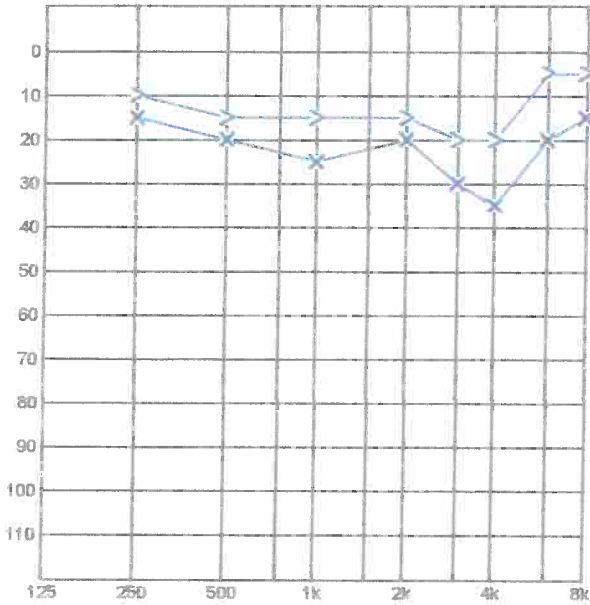
No. Rekam Medik (Medical Record)

Left Ear

PTA 22 dBHL

Right Ear

PTA 25 dBHL



Telinga Kanan

Frekuensi	250	500	1000	2000	3000	4000	6000	8000	Rata-rata
AC (dB)									
BC (dB)									

Telinga Kiri

Frekuensi	250	500	1000	2000	3000	4000	6000	8000	Rata-rata
AC (dB)									
BC (dB)									

Kesimpulan (Conclusion)

data dalam normal

Rekomendasi (Recommendation)

20/07

 Nama dokter & tanda tangan
 Doctor's name & signature

SH

**HASIL PEMERIKSAAN SPIROMETRI
SPIROMETRY REPORT**

No. Rekam Medik (*Medical Record*)

Nama (Name)

Jenis Kelamin (Sex)

Usia (Age)

Tinggi Badan (*Height*)

Berat Badan (*Weight*)

Perusahaan (*Company*)

MR : 035199
Name : DHIAN ARDITAMA, TN
Sex : M
DoB : 1979/11/07
Ward : Out Patient

38 thn

161 cm

76 kg

Inspektindo

ANAMNESIS

Keluhan (*Complaint*)

Kebiasaan Merokok (*Smoking*)

Riwayat Asthma (*Asthma*)

Parameter	Pengukuran (<i>Measurement</i>)	Prediksi (<i>Predicted</i>)	% Prediksi (% <i>Predicted</i>)
VC		4,11	
FVC	3,00	3,05	76
FEV ₁	2,8 2,79	2,8 3,33	100 84
FEV ₁ / FVC	93,0	80,40	116

* Nilai prediksi di hitung berdasarkan nilai prediksi orang Indonesia (PPI)

Kesimpulan (*Conclusion*)

- Restriksi Ringan / Sedang / Berat
 Obstruksi Ringan / Sedang / Berat
 Restriksi & Obstruksi Ringan / Sedang / Berat

Rekomendasi (*Recommendation*)

Bye 20 - 08 20 18

dr. Dian A., Sp.P

Nama dokter & tanda tangan

Doctor's name & signature

Patient Name : DHIAN ARDITAMA, TN	Order Time : 20-08-18 09:01
Address : JL. TAMAN SEPINGGAN IV, NO. 3, RT. 34	Specimen Received : 20-08-18 09:27
Age : 38 Thn 9 Bln 13 Hr	Print Out : 20-08-18 11:30
DOB/Sex : 07-11-1979 / Male	Lab No. : 18024314 /
Ward : CHECKUP /	Patient Category : INSPEKTINDO
Physician : dr. Linda Uli Natalisa	Reg. No. : CPA1808200005
MR. No. : SHBP.00035199	Page : 1 / 3

Clinical Info :

RUTIN

Test	Result	Unit	Reference Range	Method
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HAEMATOLOGY

Hematologi Lengkap

Hemoglobin	15.1	g/dL	14.0 - 18.0
Jumlah Lekosit	8.97	10 ³ /ul	4.50 - 11.50
Hitung Jenis			
Eosinofil	2	%	1 - 3
Basofil	0	%	0 - 2
Neutrofil Segmen	70	%	50 - 70
Limfosit	19	%	18 - 42
Monosit	9	%	2 - 11
Hematokrit	45.5	%	40.0 - 54.0
Jumlah Trombosit	273	10 ³ /ul	150 - 450
Jumlah Eritrosit	5.02	10 ⁶ /uL	4.60 - 6.00

MCV, MCH, MCHC

MCV	90.6	fL	80.0 - 94.0
MCH	30.1	pg	26.0 - 32.0
MCHC	33.2	g/L	32.0 - 36.0
Laju Endap Darah 1 jam	12	mm	0 - 13

CLINICAL CHEMISTRY

SGOT - SGPT

SGOT	26.0	U/L	<37
SGPT	31.3	U/L	<45

Gamma GT	25.0	U/L	8-61
Trigliserida	90	mg/dL	Normal: <150 mg/dL Borderline High: 150-199 mg/dL High: 200-499 mg/dL Very high: >= 500 mg/dL
Kolesterol Total	183	mg/dL	Desirable: <200 mg/dL Borderline High: 200-239 mg/dL High: >= 240 mg/dL
HDL Kolesterol	49	mg/dL	Major risk: <40 mg/dL Negative risk: >= 60 mg/dL

Patient Name : DHIAN ARDITAMA, TN	Order Time : 20-08-18 09:01
Address : JL. TAMAN SEPINGGAN IV, NO. 3, RT. 34	Specimen Received : 20-08-18 09:27
Age : 38 Thn 9 Bln 13 Hr	Print Out : 20-08-18 11:30
DOB/Sex : 07-11-1979 / Male	Lab No. : 18024314
Ward : CHECKUP	Patient Category : INSPEKTINDO
Physician : dr. Linda Uli Natalisa	Reg. No. : CPA1808200005
MR. No. : SHBP.00035199	Page : 2 / 3

Clinical Info :

RUTIN

Test	Result	Unit	Reference Range	Method
LDL Kolesterol	130	mg/dL	Optimal:<100 mg/dL Near optimal:100-129 mg/dL Borderline high:130-159 mg/dL High:160-189 mg/dL Very high:>190 mg/dL	
Glukosa Darah Puasa	H 102	mg/dL	76 - 100	Hexo
Ureum Darah	27.3	mg/dL	<50	
Kreatinin Darah	1.00	mg/dL	0.70 - 1.20	
Asam Urat	4.5	mg/dL	3.4 - 7.0	

SEROLOGY

HBsAg Rapid	Non Reaktif	Non Reaktif
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URINALISYS

Urin Lengkap

Makroskopis

Warna	Kuning Tua	Kuning
Kejernihan	Jernih	Jernih
Berat Jenis	1.020	1.016 -1.022
pH	6.5	4.8 - 7.4
Lekosit	Negatif	/uL Negatif
Nitrit	Negatif	mg/dL Negatif
Protein	Negatif	mg/dL Negatif
Glukosa	Normal	mg/dL Normal
Keton	Negatif	mg/dL Negatif
Urobilinogen	Normal	mg/dL Normal
Bilirubin	Negatif	mg/dL Negatif
Darah (Blood)	Negatif	/uL Negatif

Sedimen

Lekosit	0-1	/lpb	1 - 5
Eritrosit	0-1	/lpb	0 - 1
Silinder	Negatif		
Sel Epitel	0-1	/lpk	0 - 2

Patient Name : **DHIAN ARDITAMA, TN**
 Address : **JL. TAMAN SEPINGGAN IV, NO. 3, RT. 34**
 Age : **38 Thn 9 Bln 13 Hr**
 DOB/Sex : **07-11-1979 / Male**
 Ward : **CHECKUP**
 Physician : **dr. Linda Uli Natalisa**
 MR. No. : **SHBP.00035199**
 Clinical Info :

Order Time : **20-08-18 09:01**
 Specimen Received : **20-08-18 09:27**
 Print Out : **20-08-18 11:30**
 Lab No. : **18024314**
 Patient Category : **INSPEKTINDO**
 Reg. No. : **CPA1808200005**
 Page : **3 / 3**

RUTIN

Test	Result	Unit	Reference Range	Method
Kristal	Negatif		Negatif	
Bakteri	Negatif		Negatif	
Jamur	Negatif		Negatif	

COL

Faeces Rutin

Makroskopis

Warna	Coklat	Coklat
Konsistensi	Lembek	Lembek
Lendir	Negatif	Negatif
Darah	Negatif	Negatif
Bau	Khas	Khas

Mikroskopik

Lekosit	0-1	/lpb	0 - 1
Eritrosit	0-1	/lpb	0 - 1
Parasit	Negatif		Negatif
Telur Cacing	Tidak Ditemukan		Negatif

Clinical Pathologist



dr. Rita Dewi K, Sp.PK

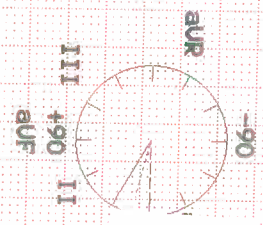
Authorized By Nur Audia
 Authorisation Date : 20-08-18 11:30

Penilaian hasil laboratorium hanya dapat diberikan oleh Dokter yang memiliki data klinis pasien.

HR 70 bpm

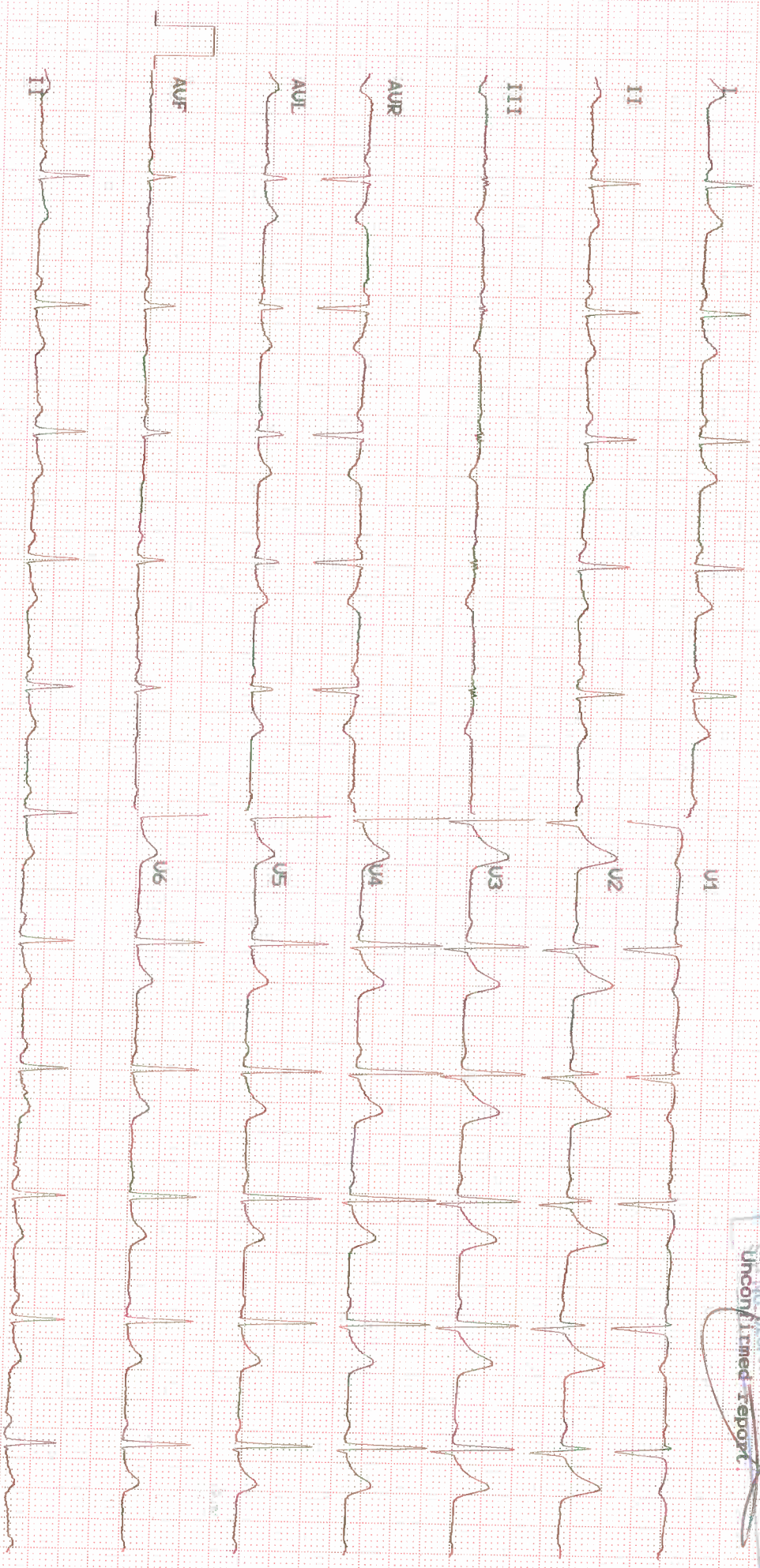
Measurement Results:

QRS	92 ms
QT/QTcB	406 / 439 ms
PR	154 ms
P	120 ms
RR/PP	854 / 850 ms
P/QRS/T	15 / 30 / 0 degrees
QTd/QTcBd	40 / 43 ms
Sokolow	2.1 mV
NK	9



< P Interpretation:

MR : 035199
 Name : DHIAN ARDITAMA, TN
 Sex : M
 DOB : 1979/11/07
 Ward : Out Patient



[Signature]

GE Healthcare
 GE MAC1200 ST
 08/155 Q/SIN
 01/11/2001
 Uncol/Imed Report

LAPORAN TREADMILL EXERCISE TEST
(PROTOKOL BRUCE)

Nama : Tn. Dhian Arditama Tanggal Treadmill : 20 Agustus 2018
 Umur : 38 Thn Berat : 76 Kg
 Jenis Kelamin : Laki - Laki Tinggi : 161 Cm
 Perusahaan : PT. Inspektindo Sinergi Tekanan Darah Awal : 110/81 mmHg

❖ Lama test : 10 Menit 13 detik

❖ Denyut Jantung maksimal : 166 x / menit

❖ Tekanan darah maksimal : 158/81 mmHg

❖ Test dihentikan karena :

- Fatigue
- Dyspnoe
- Angina
- Pusing
- Terdapat perubahan segmen ST - T
- Target denyut jantung tercapai

❖ Perubahan segmen ST - T

- Upsloping
- ST depresi 0,5 - 1 mms
- Bermakna (ST depresi > 1 mm)
- Tidak terdapat perubahan

Kapasitas Aerobik : 13.30 METs
Mets

❖ Tingkat kebugaran jasmani :

- Rendah
- Kurang
- Sedang
- Baik
- Sangat baik

❖ Response Tekanan darah :

- Normal
- Response hipertensif

KESIMPULAN:

- Response ischemic positive
- Response ischemic negative
- Borderline stress test
- Indeterminate (Target denyut jantung tidak tercapai)
- FIT / UNFIT to work in remote area

Advice :

1 _____
 2 _____

Dokter Pemeriksa
 dr. M. Iqbal, Sp. JP
 Siloam Hospitals Balikpapan

Patient ID: 0351994

20.08.2018

14:00:01

BASILINE EXERCISE
0:01
81 bpm
109/79 mmHg

MAX. ST EXERCISE
10:13
166 bpm

PEAK EXERCISE
10:13
166 bpm

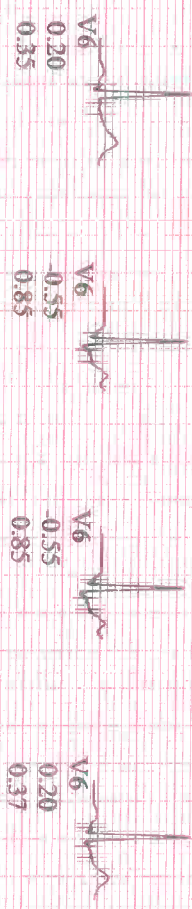
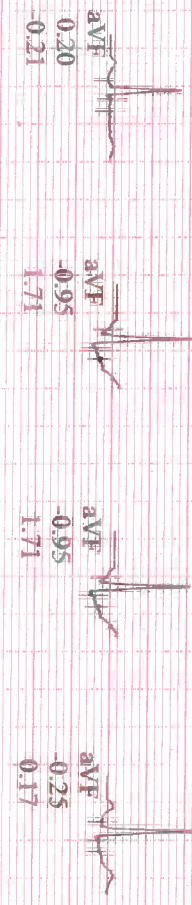
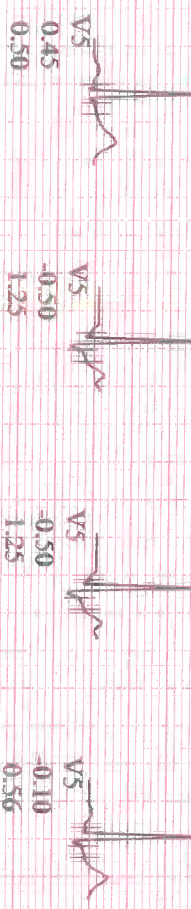
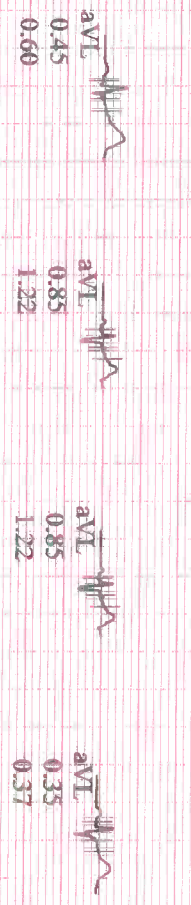
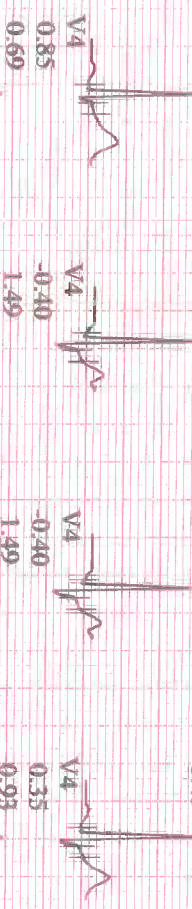
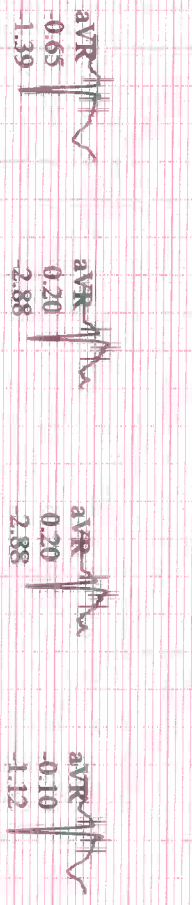
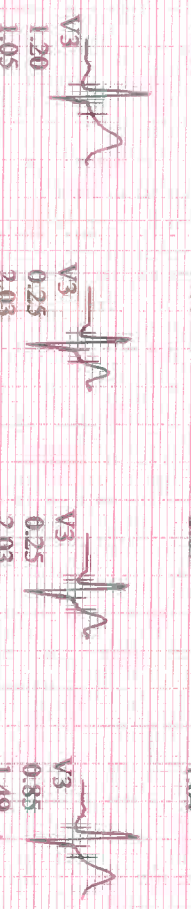
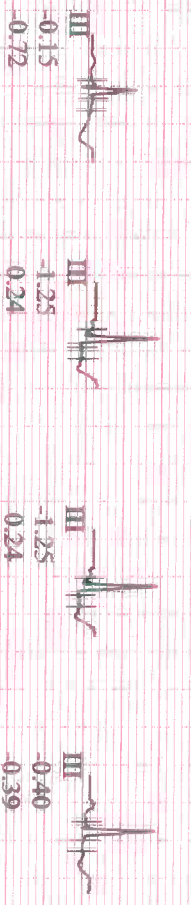
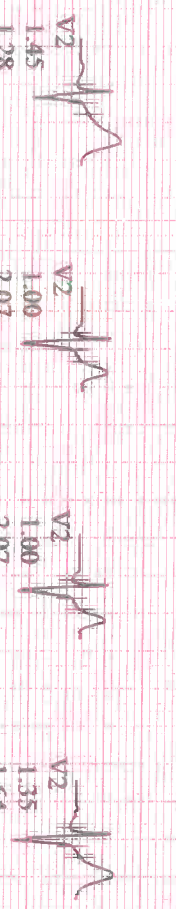
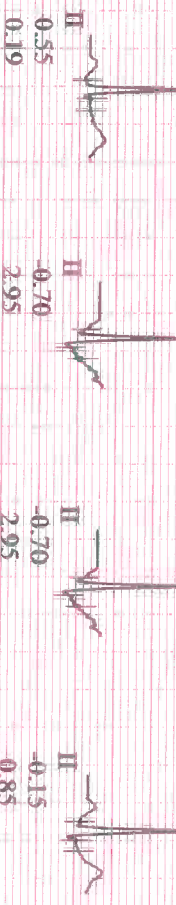
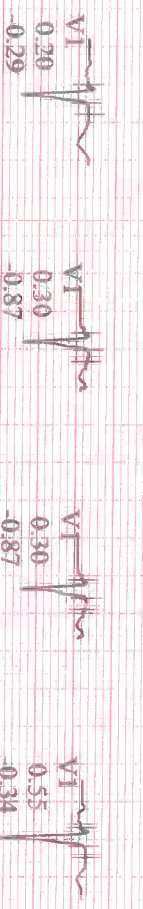
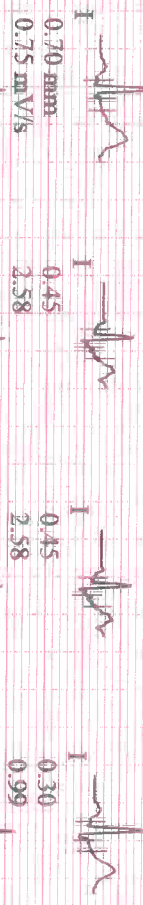
TEST END RECOVERY
3:50
118 bpm

BASILINE EXERCISE
0:01
81 bpm
109/79 mmHg

MAX. ST EXERCISE
10:13
166 bpm

PEAK EXERCISE
10:13
166 bpm

TEST END RECOVERY
3:50
118 bpm



GE CASE V6.73 (0)
10µm/mV 50Hz 0.01Hz FRF+ HEART V5.4

Unfiltered

Attending MA

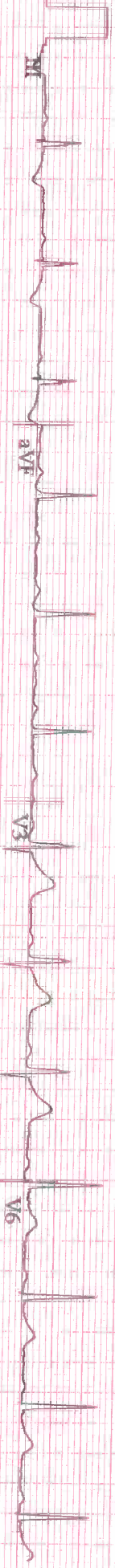
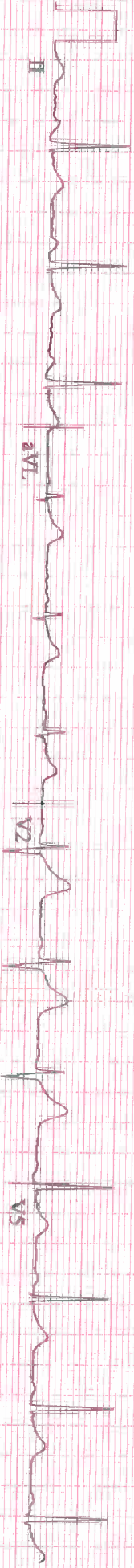
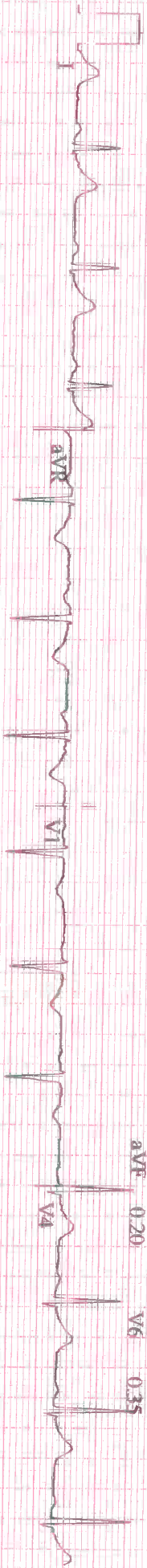
77 bpm
110.81 mmHg

PRETEST
STANDING 00:43
BRUCE 0.0 km/h
0.0 P₀

Siloam Hospital Balikpapan

Measured at 60mm Post I (10mm/mV)
Auto Points

Lead	Sr (mm)	Lead	Sr (mm)
I	0.60	V1	0.20
II	0.50	V2	1.50
III	-0.10	V3	1.25
aVR	-0.60	V4	0.85
aVL	0.35	V5	0.55
aVF	0.20	V6	0.35



GE
CASE: V673

25 mm/s 10 mm/mV 50Hz 0.01Hz FREQ. HR(V5, V4)

Start of Test: 14:00:01

U. Juman Arqulama F.I. Inspektindo Sinergi Persad
 Patient ID: 0351094
 20.08.2018
 14.01.46

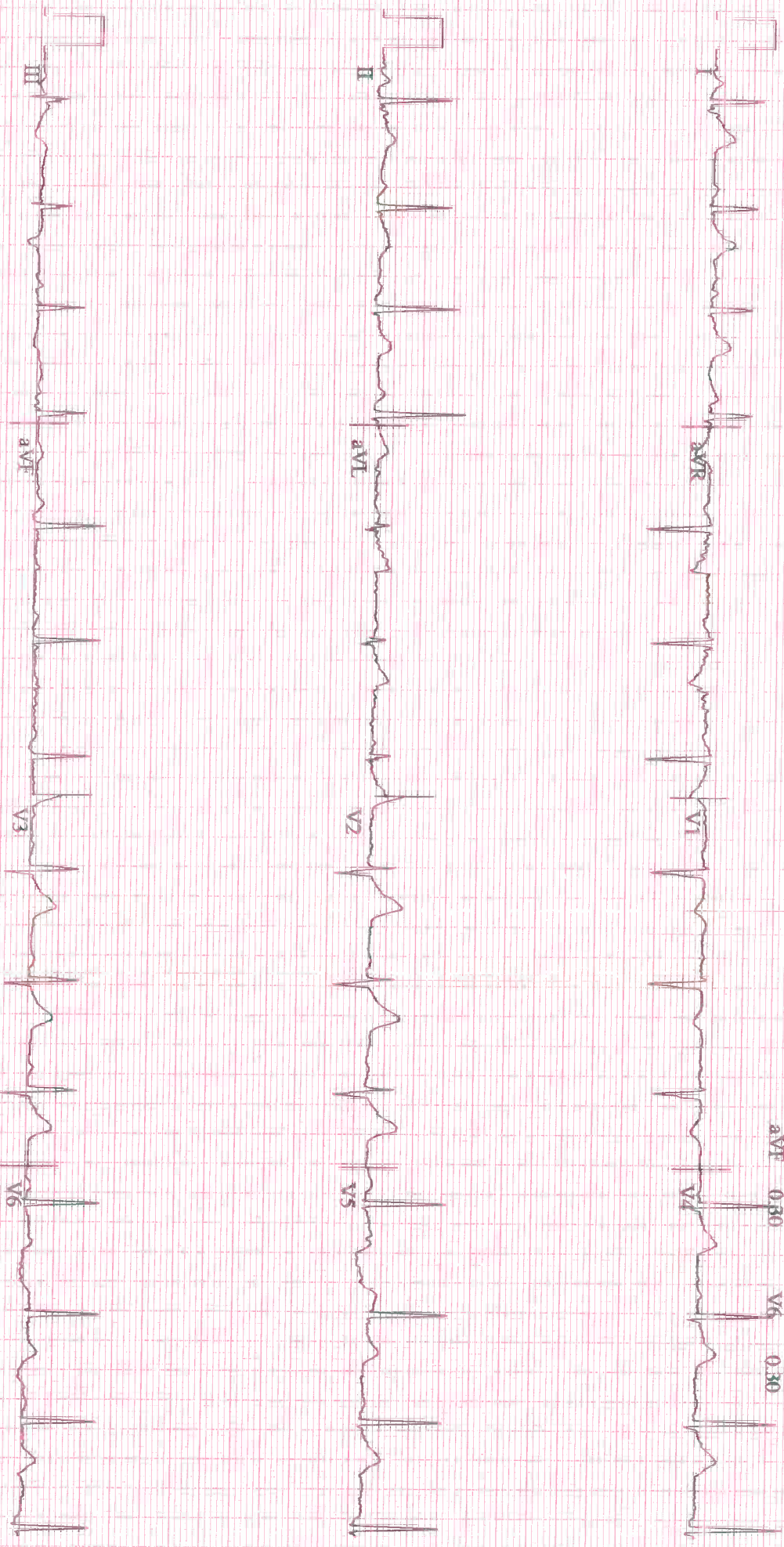
83 bpm
 109.79 mmHg

PRETEST
 WARM-UP
 01.45

BRUCE
 1.6 km/h
 0.0 °

Siloam Hospital Balikpapan
 Measured at 60ms Post J (10mm.mV)
 Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.60	V1	0.20
II	0.60	V2	1.50
III	-0.05	V3	1.25
aVR	-0.60	V4	0.85
aVL	0.30	V5	0.50
aVF	0.30	V6	0.30



GE
 CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01Hz FRT HR(V5, V4)

Start of Test 14:00:01

Patient ID: 0351994
 20.08.2018
 14:04:43

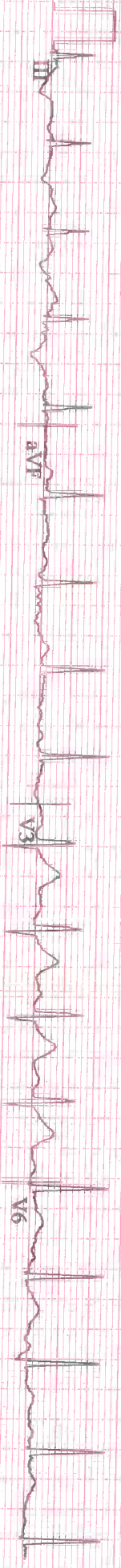
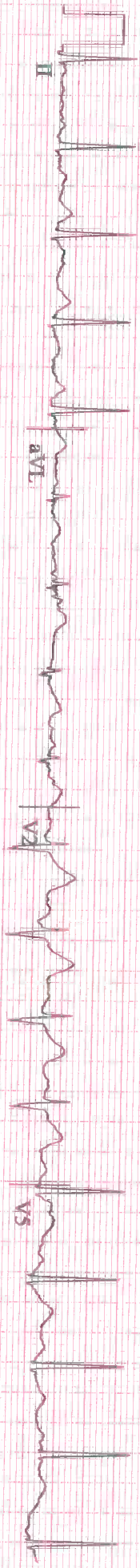
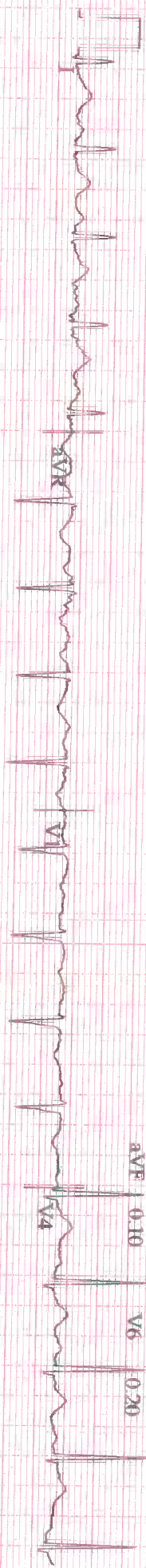
102 bpm
 117.85 mmHg

EXERCISE
 STAGE 1
 02:50

BRIJCE
 2.7 km/h
 10.0 °

Siloam Hospital Balikpapan
 Measured at 6cmh Post J (10mm mV)
 Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.40	V1	0.25
II	0.35	V2	1.30
III	-0.15	V3	1.05
aVR	-0.40	V4	0.60
aVL	0.25	V5	0.45
aVF	0.10	V6	0.20



GE
 CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01Hz FRR (V5, V4)

Start of Test: 14:00:01

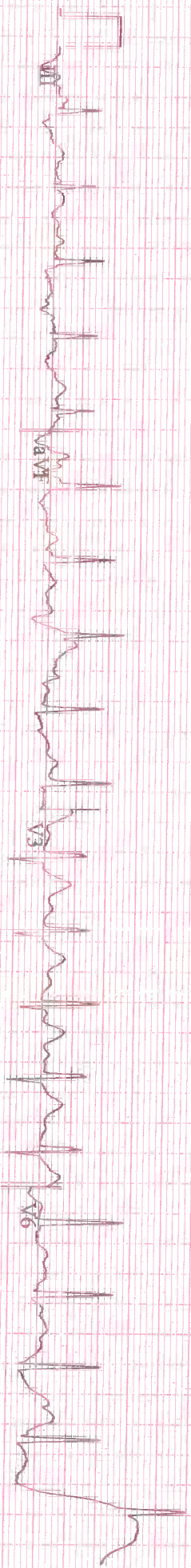
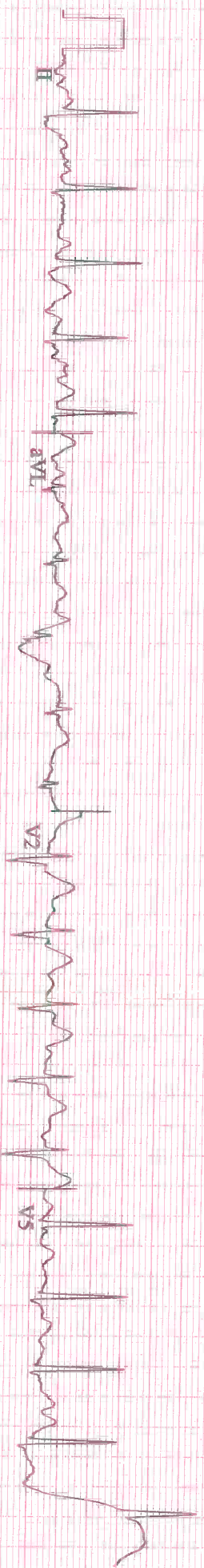
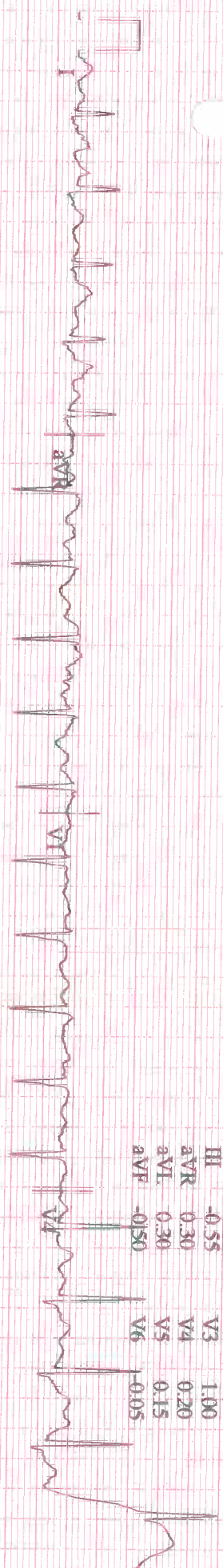
121 bpm
158.81 mmHg

EXERCISE
STAGE 2
05:50

BRUCE
3.9 km/h
12.0 %

Siloam Hospital Balikpapan
Measured at 60ms Post J (10mm mV)
Auto Points

Lead	ST(mV)	Lead	ST(mV)
I	-0.05	V1	0.75
II	-0.55	V2	1.15
III	-0.55	V3	1.00
aVR	0.30	V4	0.20
aVL	0.30	V5	0.15
aVF	-0.50	V6	-0.05



GE
CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.1mV/Hz FRT HR(V5, V4)

Start of Test: 14:00:01

No. Urutan Artotama P1, Inspeksi/Indo Sinergi Persad
Patient ID: 0351994
20.08.2018
14.10.43

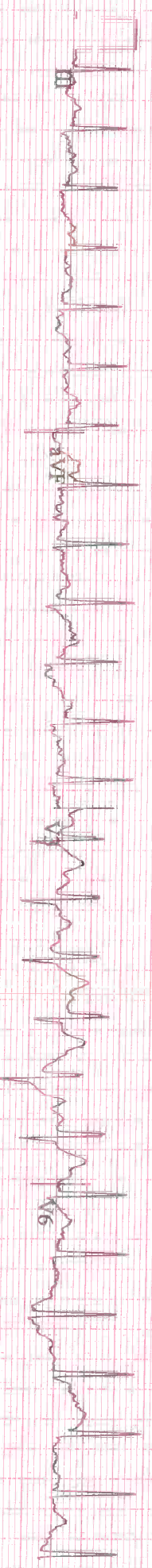
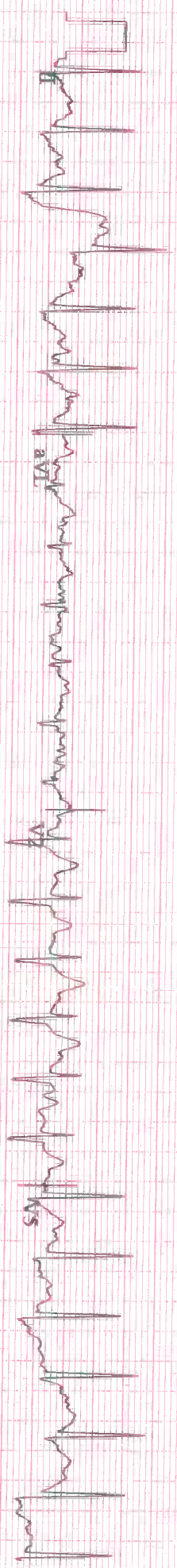
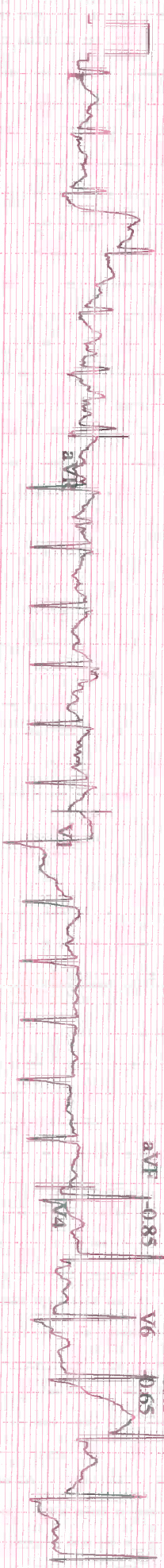
153 bpm

EXERCISE STAGE 3
08:50

BRUCE 5.3 km/h
14.0°

Siloam Hospital Balikpapan
Measured at 60ms/Post 1 (10mm mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.30	V1	0.45
II	-0.75	V2	1.15
III	-1.00	V3	0.60
aVR	0.20	V4	-0.10
aVL	0.65	V5	-0.45
aVF	-0.85	V6	0.65



GE
CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01mV FRF - HR(V6,V5)

Start of Test: 14:00:01

Patient ID: 0351994
20.08.2018
14:12:06

166 bpm

BRDCE
6.7 km/h
16.0 °

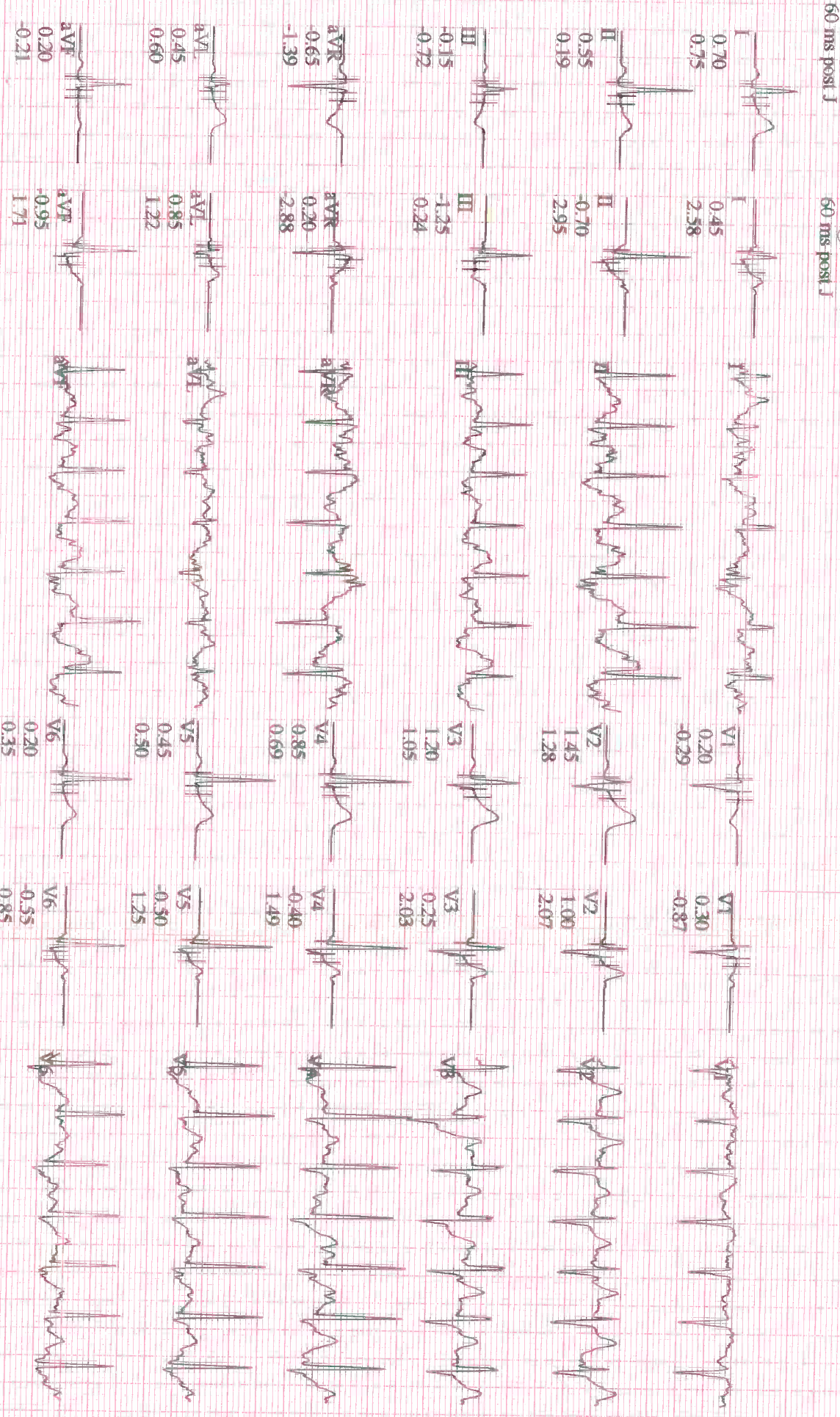
BASELINE

CURRENT
ST @ 10mm/mV
60 ms post J

BASELINE

CURRENT

Lead
ST Level (mm)
ST Slope (mV/s)



GE

CASE V6173

25 mm/s 10 mm/mV 50Hz 0.01Hz ERI - HIRI(V6,V5)

Start of Test: 14:00:01

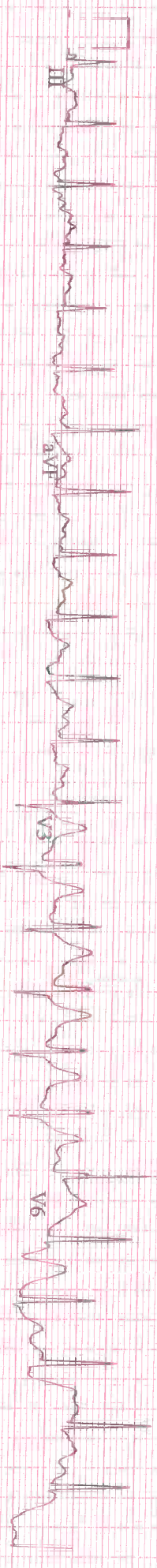
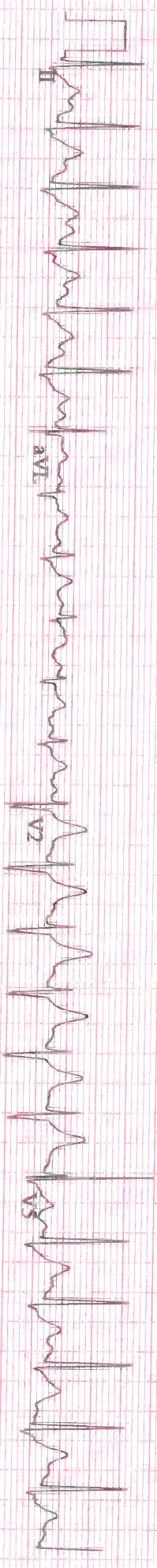
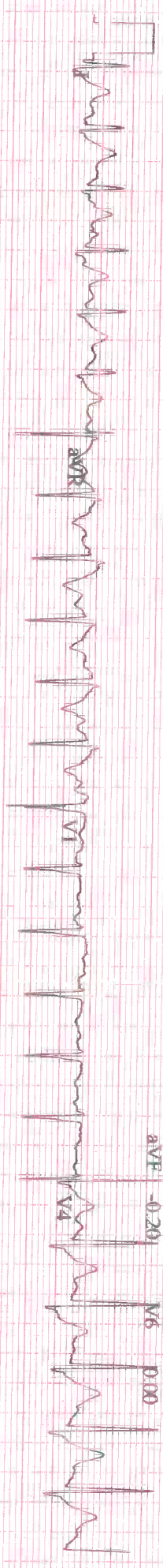
No. Urutan Anamnesa P1 - Inspeksiindo Sinergi Painsad
Patient ID: 0351994
20.08.2018
14:12:56

146 bpm

RECOVERY #1
00:50
BRUCE
2.4 km/h
0:0:0⁰

Siloam Hospital Bahikpapan
Measured at 60ms Post-T (10mm mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.40	V1	0.75
II	0.00	V2	1.80
III	-0.40	V3	1.30
aVR	-0.20	V4	0.30
aVL	0.40	V5	0.05
aVF	-0.20	V6	0.00



GE
CASE: V6.73

25 mm/s 10 mm/mV 50Hz 0.010s PRF HR(V6,V5)

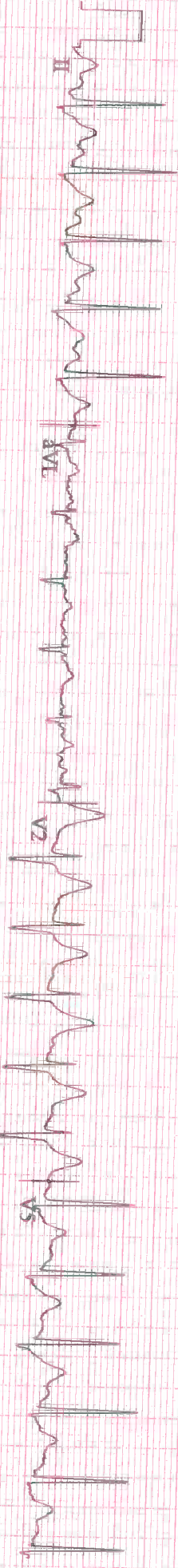
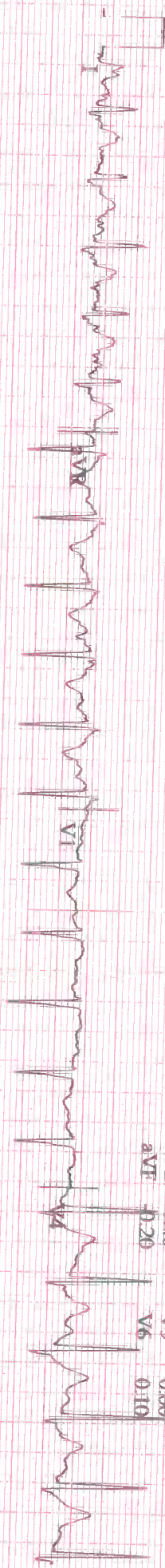
Start of Test: 14:00:01

133 bpm

RECOVERY #1
 01:50
 BRUCE
 2.4 km/h
 (0.0 m/s)

Siloam Hospital Balikpapan
 Measured at 60ms Post J (10mm mV)
 Auto Points

Lead	ST (mm)	Lead	ST (mm)
I	0.40	V1	0.80
II	0.00	V2	1.75
III	-0.40	V3	1.35
aVR	-0.20	V4	0.30
aVL	0.40	V5	0.00
aVF	0.20	V6	0.10



GE
 CASE V6.73

25 mm s 10 mm mV 50Hz 0.10Hz EPR HIR(V6,V5)

122 bpm
 124.58 mmHg

RECOVERY #1
 02:50

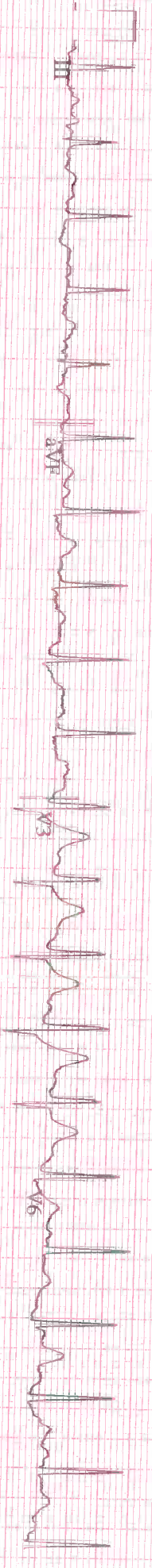
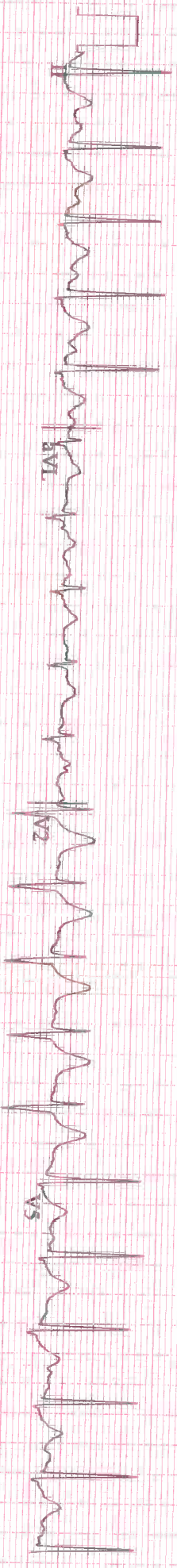
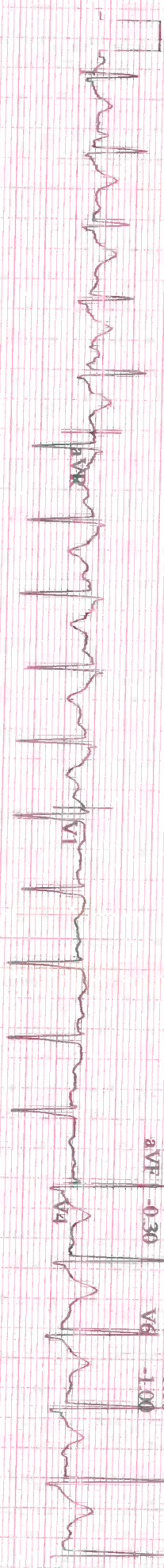
BRUCE
 2.4 km/h
 0.0%

Siloam Hospital Batik Papua

Measured at 60ms Post J (10mm mV)

Auto Points

Lead	ST (mm)	Lead	ST (mm)
I	0.25	V1	0.80
II	-0.15	V2	1.55
III	-0.45	V3	1.00
aVR	-0.05	V4	0.10
aVL	0.35	V5	-0.10
aVF	-0.30	V6	-1.00



GE

CASE V673

25 mm s 10 mm mV 50HZ DIGITZ PRF BR(V6,V5)

118 bpm

RECOVERY #1

03:50

BRUCE

2.4 km/h

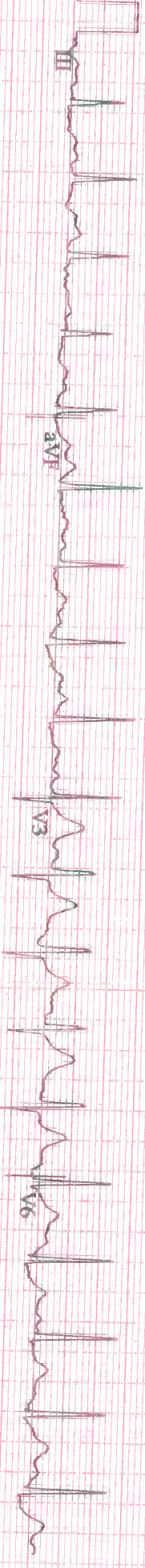
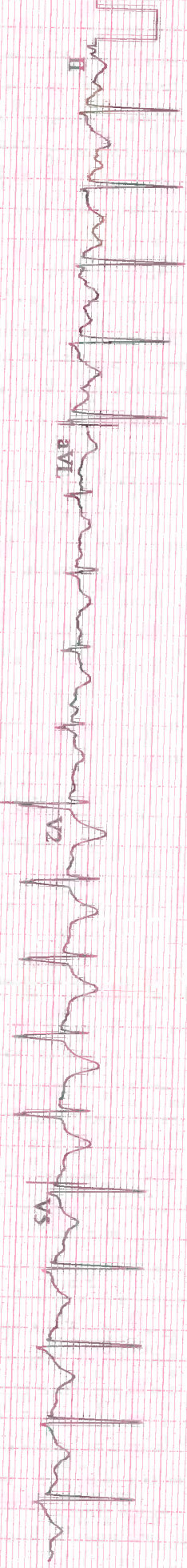
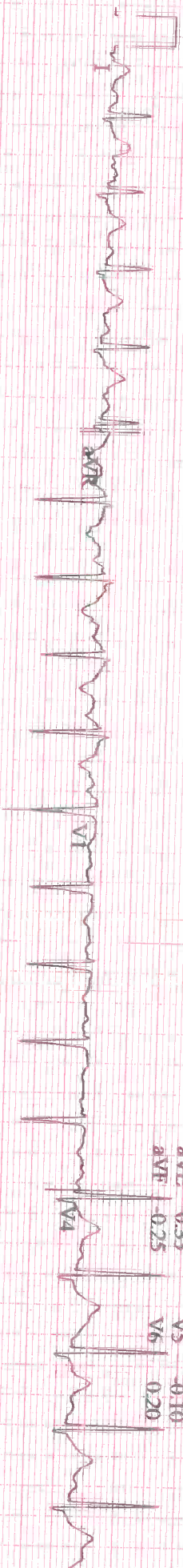
10.0%

Siloam Hospital Batikpapan

Measured at 60mm Post J (10mm mV)

Auto Points

Lead	ST (mm)	Lead	ST (mm)
I	0.39	V1	0.55
II	-0.15	V2	1.35
III	-0.40	V3	0.85
aVR	-0.10	V4	0.35
aVL	0.35	V5	-0.10
aVF	-0.25	V6	0.20



GE

CASE 5373

25 mm s 10 mm mV 50Hz 0.01Hz FRR HR(V6,V5)

Patient Name	: DHIAN ARDITAMA, TN	Patient ID	: SHBP.00035199
Sex / Age	: M / 038Yrs	Accession No.	: 10000006457804
Modality	: US	Scan Date	: 20-08-2018
Procedure	: UPPER ABDOMEN USG	Report Date/Time	: 20-08-2018 12:48:49
Ref. Department	: MCU	Referring Physician	: dr. Linda UI Natalisa

US- Upper Abdomen, Male

Technique:

Findings:

- HEPAR: Normal
- LIEN: Normal
- SISTEM VENA PORTA: Normal
- VENA CAVA INFERIOR, VENA HEPATIKA: Normal
- SISTEM BILIER: Normal
- ITUNG EMPEDU: Normal
- PANKREAS: Normal
- GINJAL:
 - KANAN: Normal
 - KIRI: Normal

Impression:

**Pria, 38 Thn pro MCU pd USG Upper Abdomen :
Tidak diketemukan adanya kelainan yg significans**



dr. Santoso Suhendro. Sp. Rad (K)

This document is digitally signed and hence no manual signature is required.