

RAHASIA



Inspektindo Sinergi Persada, PT

HEALTH AND MEDICAL CHECK UP

No. 0046/MCU-SHBP/VIII/2016

Nama : **Pambudhi Kristyanto, Tn**
Tanggal Lahir : **18 Juli 1981**
Jenis Kelamin : **Male**
S/N :
Jabatan / Posisi : -

Tanggal MCU : **10 Agustus 2016**

Dilakukan oleh : **dr. Linda Uli Natalisa**
dr. Santoso Suhendro, Sp. Rad
dr. M. Iqbal, SP. JP
dr. Maranatha, SP THT - KL
dr. Ademalla Kirana, Sp. P

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RAHASIA

HEALTH AND MEDICAL CHECK UP

No. 0046/MCU-SHBP/VIII/2016

Kepada : **Pambudhi Kristyanto, Tn** Umur/ Tanggal **35 tahun 18 Jul 1981** **Male**
Dept : **Inspektindo Sinergi Persada, PT**

Berikut adalah hasil pemeriksaan Medical Check Up yang telah dilaksanakan pada tanggal **10 Agustus 2016**

TEMUAN

1. Laboratorium DL : Kolesterol meningkat.
2. Laboratorium UL : BJ meningkat.
3. USG abdomen : Cholelithiasis multiple.

STATUS

CATEGORY	
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 _____ - _____ di Lokasi Kerja **Inspektindo Sinergi Persada, PT**

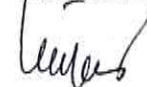
SARAN

1. Rutin berolahraga.
2. Hindari makanan yang tinggi kolesterol.
3. Konsultasi ke Dokter Spesialis Penyakit Dalam untuk evaluasi hasil USG abdomen adanya Cholelithiasis.

Berlaku :

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

Dokter Pemeriksa,



dr. Linda Uli Natalisa

RAHASIA

Diisi oleh Dokter

Medical Department

HEALTH AND MEDICAL CHECK UP

PHYSICAL EXAMINATION

Name	Pambudhi Kristyanto, Tn	S/N		DEPT	Spektindo Sinergi Persada, F
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I. GENERAL CONDITION

Blood Pressure (mmHg)	110/80	Pulse (x/mnt)	80	Respiration (x/mnt)	20	Temp (° C)	0
Weight (kg)	59	Height (cm)	162	BMI (kg/m ²)	22,48	Waist (cm)	0

* 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		Protesa
8	NECK	Adenopathi/Thyroid/Carotids/Trachea/Veins/Mass/Spine/Motion/Bruit		N	-
9	BACK/SPINE	Kyphosis/Scoliosis/Lordosis/mobility/CVA/Bone/Tenderne ss/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/Hernias,murmur/ contour/tenderness/bruit/nodes		N	-
15	GROIN	Hernia/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/rectocele/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,vibrat e)/coordination/romberg		N	-
22	MUSCULAR SYSTEM	Strength/wasting/development		N	-
23	RECTAL EXAM	Sphincter tone/hemorrhoids/fissure/masses/prostate		N	-

SUPPORTIVE INVESTIGATIONS

Name

Pambudhi Kristyanto, Tn

I. VISION

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

II. LABORATORIUM SUMMARY

<input type="checkbox"/> Normal	COMMENT :	Laboratorium DL : Kolestrol meningkat → UL : BJ 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 :	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	3.67	3.07	84	%
FVC	3.11	2.67	86	%
FEV ₁	80.9	86.9	107	%
FEV ₁ /FVC	8.59	9.82	114	%
COMMENT :		Normal		

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

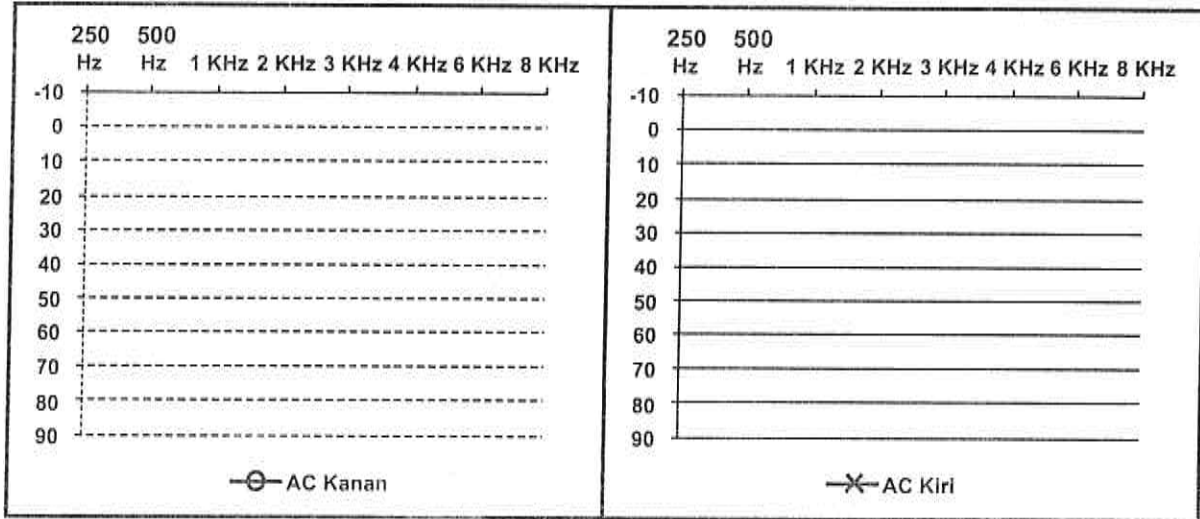
VIII. USG

COMMENT :	Tidak dilakukan pemeriksaan
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SH

HASIL PEMERIKSAAN AUDIOMETRI
AUDIOMETRY REPORT

No. Rekam Medik (*Medical Record*) _____
 Nama (*Name*) _____
 Jenis Kelamin (*Sex*) _____
 Usia (*Age*) _____
 Perusahaan (*Company*) _____



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)

tidak terdengar

Rekomendasi (Recommendation)

dr. Maranatha Lumban Batu, Sp. THT-KI

 Otolaryngologist (H)

 20 16

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*) _____

ANAMNESIS

Keluhan (*Complaint*) _____

Kebiasaan merokok (*Smoking*) _____

Riwayat Asma (*Asthma*) _____

Parameter	Pengukuran (<i>Measurement</i>)	Prediksi (<i>Predicted</i>)	% Prediksi (<i>% Predicted</i>)
VC			
FVC			
FEV ₁			
FEV ₁ / FVC			

* Nilai prediksi dihitung berdasarkan nilai prediksi orang Indonesia (PPI)

Kesimpulan (*Conclusion*)

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

Rekomendasi (*Recommendation*)

..... Bgn 60/87 2016

dr. Ademallo Kirana N, Sp.P
Pulmonologisi

Nama dokter & tanda tangan
Doctor's name & signature

NAME

02/JUL/2016 AM 11:55

		mmHg		AVG
R	13	12	14	13
L	15	14	16	15

CT-80 TOPCON

SH

MR : **087152**
 Name : **PAMBUDHI K**
 Sex : **M**
 DoB : **1981/07/18**
 Ward : **Out Patient**

FORMULIR PEMERIKSAAN MATA
EYE EXAMINATION FORM

OD / RE

OS / LE



Mata Kanan (Right Eye)	Parameter	Mata Kiri (Left Eye)
<u>6/6</u>	Visus (Visual acuity)	<u>6</u>
	Koreksi (correction)	-
<u>6/20</u>	Adisi (Addition)	<u>20/20</u>
None	Gerakan Bola Mata (Eye movement)	None
	Kesegaran (Allignment)	
	Kelopak Mata (Eyelid)	
	Konjungtiva (Conjunctiva)	
	Kornea (Cornea)	
	Bilik Mata Depan (COA)	
	Pupil	
	Iris	
	Lensa (Lens)	
	Vitreous	
	Fundus	
<u>13</u>	TIO	<u>15</u>
	Lapang Pandang (Visual field)	
	Persepsi Warna (Color Perception)	

Kesimpulan ODS Emmetropia

Ben

6/8

20/16

 Nama dokter & tanda tangan
 Doctor's name & signature

Patient Name : PAMBUDHI KRISTYANTO, TN
 Address : JL. TELOGO REJO NO 35 RT 29 76111
 Age : 35 Thn 0 Bln 23 Hr
 DOB/Sex : 18-07-1981 / Male
 Ward : MEDICAL CHECK UP
 Physician : LINDA ULI NATALISA, dr
 MR. No. : 087152
 Clinical Info :

Order Time : 10-08-16 08:21
 Specimen Received : 10-08-16 08:24
 Print Out : 10-08-16 12:29
 Lab No. : 16029535
 Patient Category : INSPEKTINDO SINERGI F
 Reg. No. : 2016081000270003
 Page : 1 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
HAEMATOLOGY				
Hematologi Lengkap				
Hemoglobin	15.7	g/dL	14.0 - 18.0	
Jumlah Lekosit	4.67	$10^3/\mu\text{l}$	4.50 - 11.50	
Hitung Jenis				
Eosinofil	3	%	1 - 3	
Basofil	0	%	0 - 2	
Neutrofil Segmen	53	%	50 - 70	
Limfosit	36	%	18 - 42	
Monosit	8	%	2 - 11	
Hematokrit	45.9	%	40.0 - 54.0	
Jumlah Trombosit	240	$10^3/\mu\text{l}$	150 - 450	
Jumlah Eritrosit	5.46	$10^6/\mu\text{L}$	4.60 - 6.00	
MCV, MCH, MCHC				
MCV	84.1	fL	80.0 - 94.0	
MCH	28.8	pg	26.0 - 32.0	
MCHC	34.2	g/L	32.0 - 36.0	
Laju Endap Darah 1 jam	1	mm	0 - 13	
CLINICAL CHEMISTRY				
SGOT - SGPT				
SGOT	17.1	U/L	<37	
SGPT	19.8	U/L	<45	
Gamma GT	32.0	U/L	8-61	
Trigliserida	112	mg/dL	Normal: <150 mg/dL Borderline High: 150-199 mg/dL High: 200-499 mg/dL Very high: \geq 500 mg/dl	
Kolesterol Total	H 228	mg/dL	Desirable: <200 mg/dL Borderline High: 200-239 mg/dL High: \geq 240 mg/dL	PAP
HDL Kolesterol	61	mg/dL	Major risk: <40 mg/dL Negative risk: \geq 60 mg/dL	

Patient Name : **PAMBUDHI KRISTYANTO, TN**
 Address : JL.TELOGO REJO NO 35 RT 29 76111
 35 Thn 0 Bln 23 Hr
 DOB/Sex : 18-07-1981 / Male
 Ward : MEDICAL CHECK UP
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 Reg. No. : 2016081000270003
 Page : 2 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
LDL Kolesterol	158	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	96	mg/dL	76 - 100	
Ureum Darah	24.8	mg/dL	<50	
Kreatinin Darah	0.84	mg/dL	0.70 - 1.20	
Asam Urat	6.1	mg/dL	3.4 - 7.0	
SEROLOGY				
HBsAg Rapid	Non Reaktif		Non Reaktif	
URINALISYS				
Urin Lengkap				
Makroskopis				
Warna	Kuning Tua		Kuning	
Kejernihan	Jernih		Jernih	
Berat Jenis	H 1.025		1.016 -1.022	Dipsticks
pH	6.0		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	1-2	/lpb	1 - 5	
Eritrosit	0-1	/lpb	0 - 1	
Silinder	Negatif			

Patient Name : **PAMBUDHI KRISTYANTO, TN**
 Address : **JL.TELOGO REJO NO 35 RT 29 76111**
 35 Thn 0 Bln 23 Hr
 DOB/Sex : **18-07-1981 / Male**
 Ward : **MEDICAL CHECK UP**
 Physician : **LINDA ULI NATALISA, dr**
 MR. No. : **087152**

Order Time : **10-08-16 08:21**
 Specimen Received : **10-08-16 08:24**
 Print Out : **10-08-16 12:29**
 Lab No. : **16029535**
 Patient Category : **INSPEKTINDO SINERGI F**
 Reg. No. : **2016081000270003**
 Page : **3 / 3**

RUTIN

Test	Result	Unit	Reference Range	Method
Sel Epitel	0-1	/lpk	0 - 2	
Kristal	Negatif		Negatif	
Bakteri	Negatif		Negatif	
Lain-lain	Ca Oxalat (+)			
STOOL				
Faeces Rutin				
Makroskopis				
Warna	Cokelat Tua		Coklat	
Konsistensi	Lembek		Lembek	
Lendir	Negatif		Negatif	
Darah	Negatif		Negatif	
Bau	Khas		Khas	
Mikroskopik				
Lekosit	0-2	/lpb	0 - 1	
Eritrosit	0-1	/lpb	0 - 1	
Telur Cacing	Tidak Ditemukan		Negatif	
Parasit	Negatif		Negatif	

Clinical Pathologist



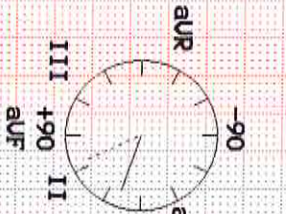
dr. Maria Enrica, Sp.PK

Authorized By ARIYANTI
 Authorisation Date : 10-08-16 12:29

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

Measurement Results:

QRS	:	92 ms
QT/QTcB	:	398 / 422 ms
PR	:	178 ms
P	:	112 ms
RR/PP	:	870 / 855 ms
P/QRS/T	:	65 / 20 / 20 degrees
QTd/QTcBd	:	44 / 47 ms
Sokolow	:	2.6 mV
NK	:	9

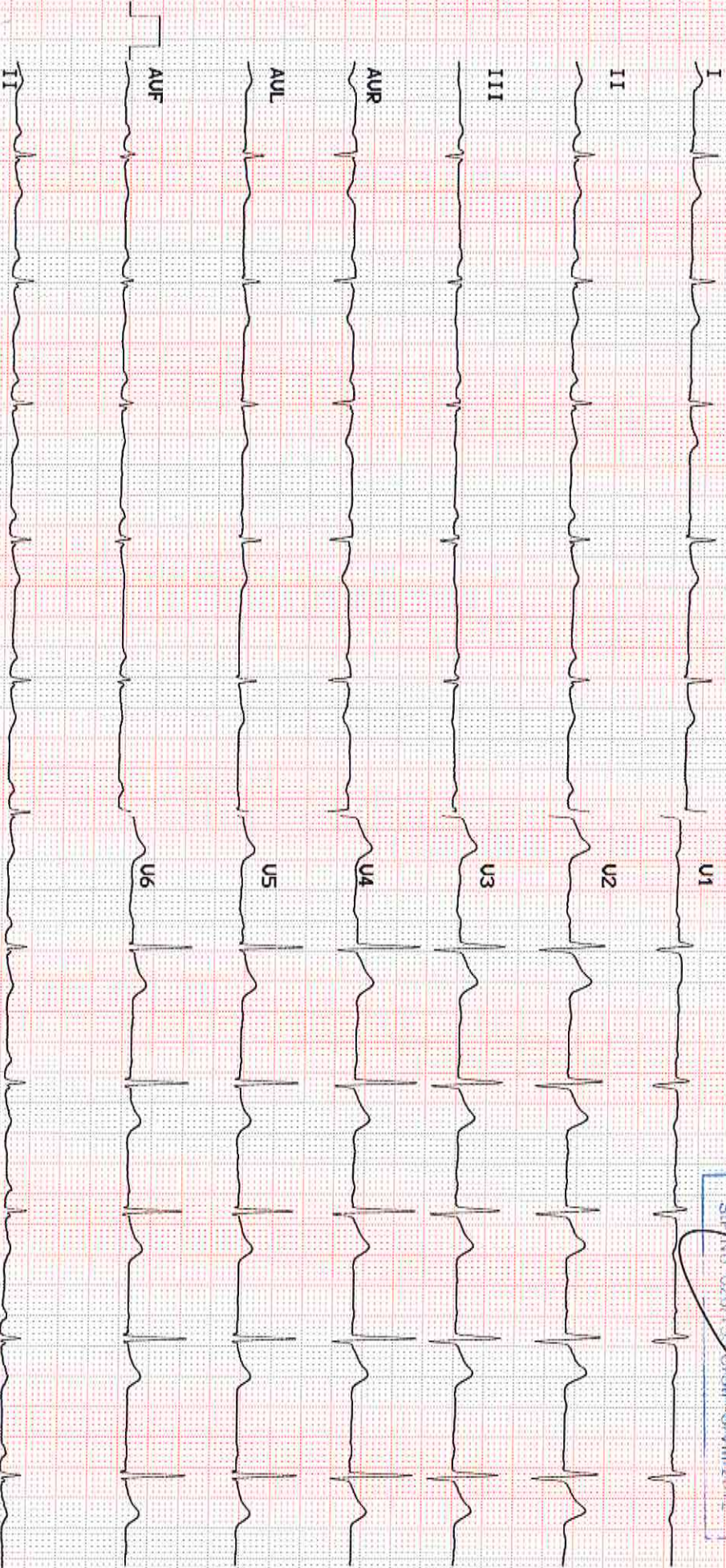


Interpretation:

Pambuchi
087152

[Signature]

dr. ~~Indartimada~~ Satrio
 dr. ~~Indartimada~~ Satrio
 SIP: 0201155/CSIP-S.VIII/2012



LAPORAN TREADMILL EXERCISE TEST
(PROTOKOL BRUCE)

Nama : Tn. Pambudhi Tanggal Treadmill : 10 Agustus 2016
Umur : 35 thn Berat : 59 kg
Jenis Kelamin : Laki - Laki Tinggi : 162 cm
Perusahaan : PT. Inspektindo Tekanan Darah Awal : 113/78 mmHg

❖ Lama test : 12 Menit 01 Detik

❖ Denyut Jantung maksimal : 173x/menit

❖ Tekanan darah maksimal : 164/101mmHg

❖ 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 : 13.50 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. Muhammad Iqbal, Sp.JP

Dr.M.Iqbal, Sp.JP

Siloam Hospitals Balikpapan

Patient ID: 0871522
 10/08/2016 Male 162 cm 59 kg
 13:21:13 35yrs Asian

Meds:

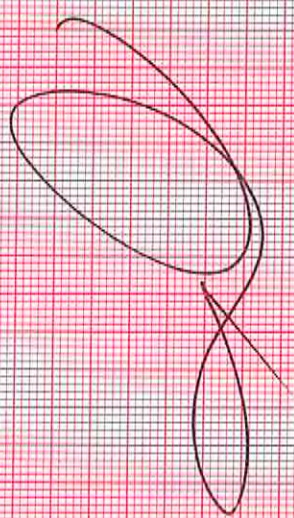
Test Reason:
 Medical History:

Ref. MD: Ordering MD:
 Technician: Fitri Test Type:
 Comment:

BRUCE: Total Exercise Time 12:01
 Max HR: 173 bpm 93% of max predicted 185 bpm HR at rest: 73
 Max BP: 164/101 mmHg BP at rest: 113/78 Max RPP: 28044 mmHg* bpm
 Maximum Workload: 13.50 METS
 Max. ST: -0.30 mm, 0.00 mV/s in HI EXERCISE STAGE 3 06:30
 HR reserve used: 89 %
 HR recovery: 36 bpm
 Freq. VE recovery: 0 VE/min
 ST/HR hysteresis: -0.027 mV (I)
 QRS duration: BASELINE: 84 ms, PEAK EX: 80 ms, REC: 84 ms
 Location Number: * 0 *

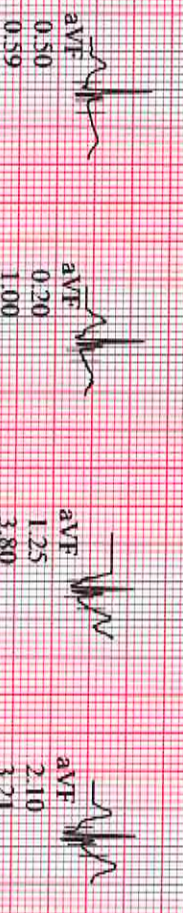
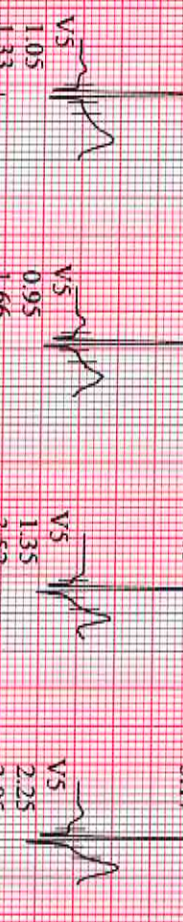
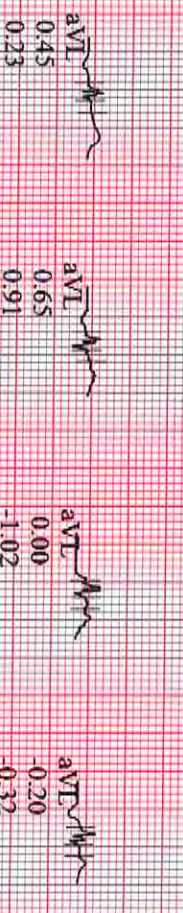
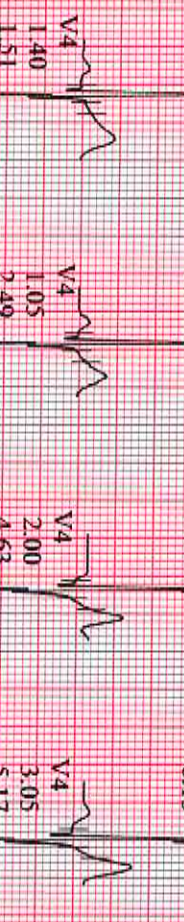
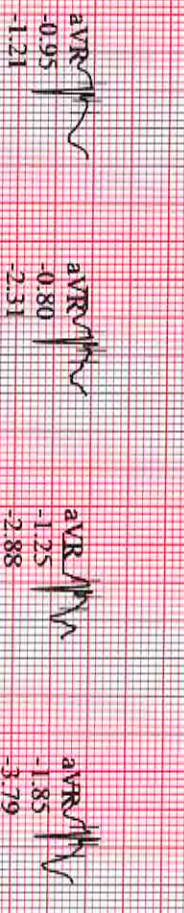
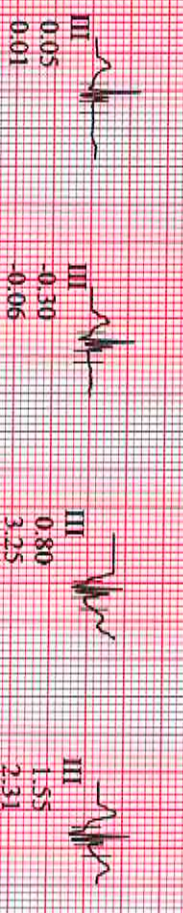
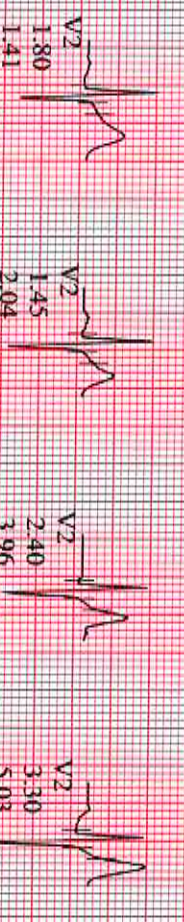
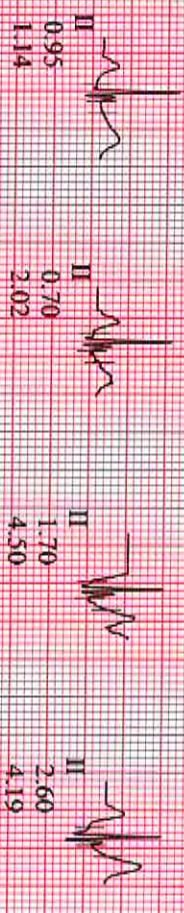
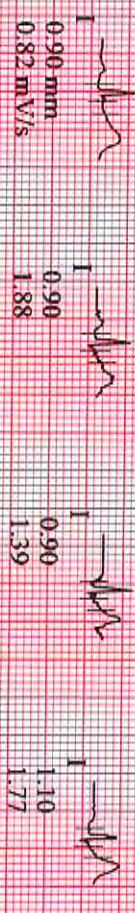
Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	Workload (METs)	HR (bpm)	BP (mmHg)	RPP (mmHg* bpm)	VE (l/min)	ST Level (mV)	Comment
PRETEST	SUPINE	00:02	0.00	0.00	1.0	73			0	0.10	
	STANDING	00:48	0.00	0.00	1.0	72	113/78	8136	0	-0.05	
	HYPERV.	00:02	0.00	0.00	1.0	72			0	-0.05	
	WARM-UP	01:02	1.60	0.00	1.7	78	113/81	8814	0	0.10	
	STAGE 1	03:00	2.70	10.00	4.6	91	112/77	10192	0	0.00	
EXERCISE	STAGE 2	03:00	4.00	12.00	7.0	114	129/74	14706	0	0.10	
	STAGE 3	03:00	5.40	14.00	10.0	137	138/75	18906	0	0.00	
	STAGE 4	03:00	6.70	16.00	13.3	173	164/101	28372	0	0.50	
	STAGE 5	00:02	7.20	16.60	13.3	173			0	0.80	
	RECOVERY		01:06	2.40	0.00	2.1	133	122/56	16226	0	1.30

Ngjane baik & Respon



BASELINE EXERCISE	MAX ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0-01 79 bpm 113/81 mmHg	6:30 134 bpm 129/74 mmHg	12:02 173 bpm 164/101 mmHg	0:59 139 bpm 122/56 mmHg

BASELINE EXERCISE	MAX ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
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GE CASE V6 73 (0)
10mm/mV 50Hz 0.01Hz FRF+ HEART VS.4
Unc timed

Attending: M.

In: Pambudi PT, Inspektando
 Patient ID: 0871522
 10.08.2016
 13:22:02

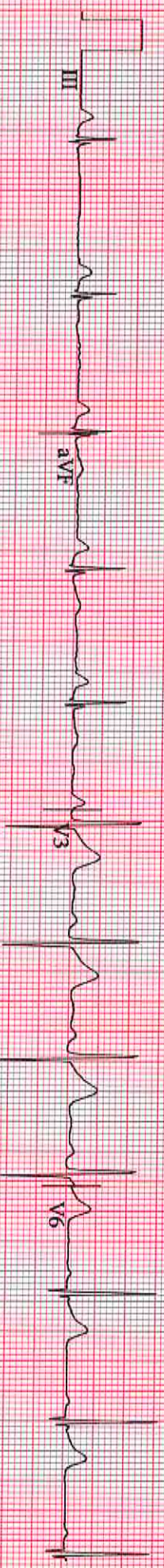
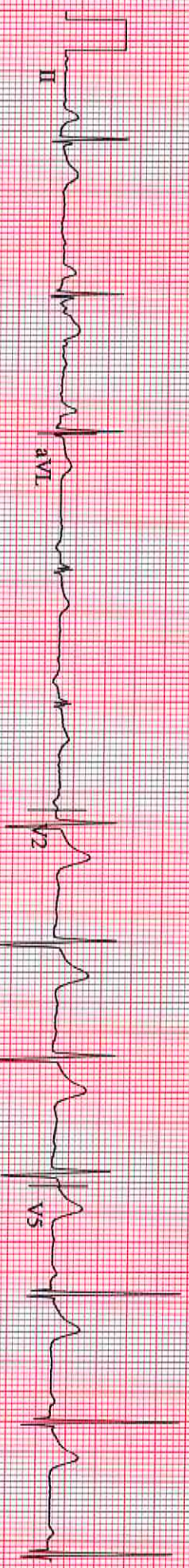
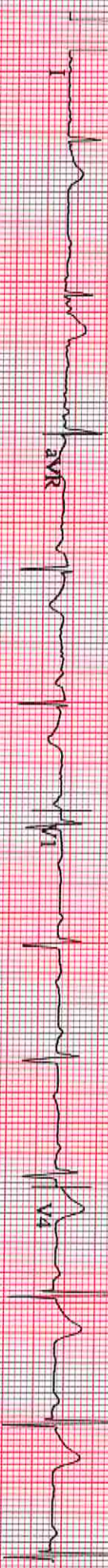
74 bpm
 113/78 mmHg

PRETEST
 STANDING
 00:48

BRUCE
 0.0 km/h
 0.0 %

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

Lead	ST(mm)	Lead	ST(mm)
I	0.90	V1	0.45
II	0.90	V2	1.85
III	0.00	V3	1.75
aVR	-0.90	V4	1.35
aVL	0.45	V5	1.10
aVF	0.50	V6	0.65



GE
 CASE V6.73

25 mm/s 10 mm/mV SOHZ. 001Hz FRF+ HR(V4,V5)

Start of Test 13:21:13

In: ambudi P.T. Inspektindo
 Patient ID: 0871522
 10/08/2016
 13:23:00

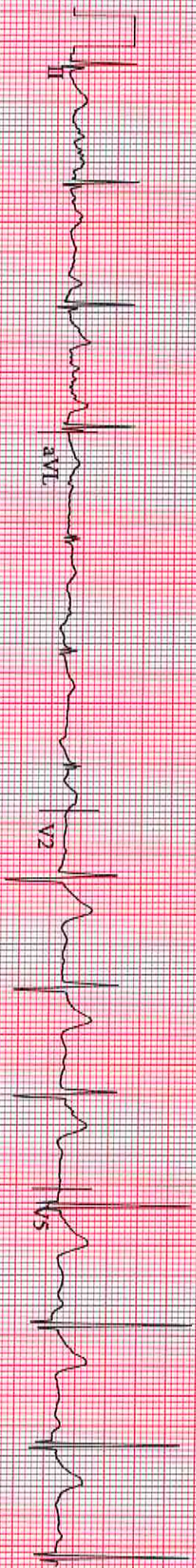
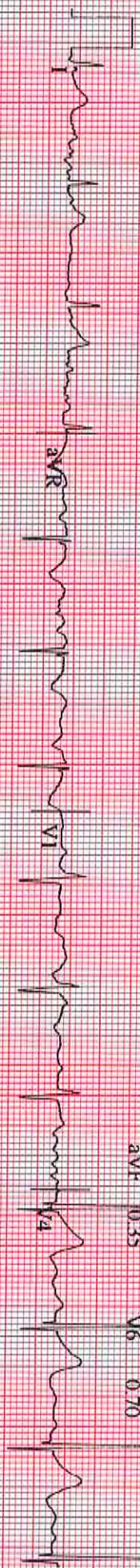
82 bpm
 113/81 mmHg

PRETEST
 WARM-UP
 01:46

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	0.85	V1	0.55
II	0.75	V2	1.75
III	-0.10	V3	1.65
aVR	-0.80	V4	1.35
aVL	0.50	V5	1.00
aVF	0.35	V6	0.70



GE
 CASE V6.73
 25 mm/s 10 mm/mV 50Hz 0.01Hz FRR+ HR(V4,V5)

Start of Test: 13:21:13

Tn. Pambudi PT. Inspektindo
 Patient ID: 0871522
 10-08-2016
 13:25:55

89 bpm
 112.77 mmHg

EXERCISE
 STAGE 1
 02:50

BRUCE
 2.7 km/h
 10.0 %g

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

Lead	ST(mm)	Lead	ST(mm)
I	0.80	V1	0.45
II	0.85	V2	1.70
III	0.00	V3	1.60
aVR	-0.85	V4	1.30
aVL	0.40	V5	1.05
aVF	0.45	V6	0.70



GE
 CASE V673
 25 mm/s 10 mm/mV 50Hz 0.01Hz FRF+ HR(V4,V5)

Start of Test: 13:21:13

Tn: ambudi P.T. Inspektindo
 Patient ID: 1871522
 10.08.2011
 13:28:55

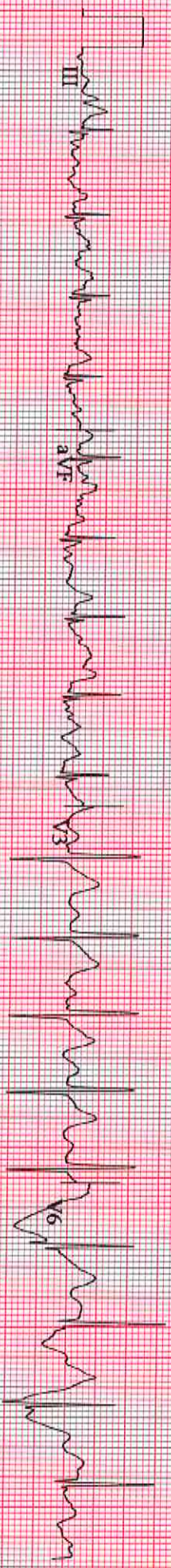
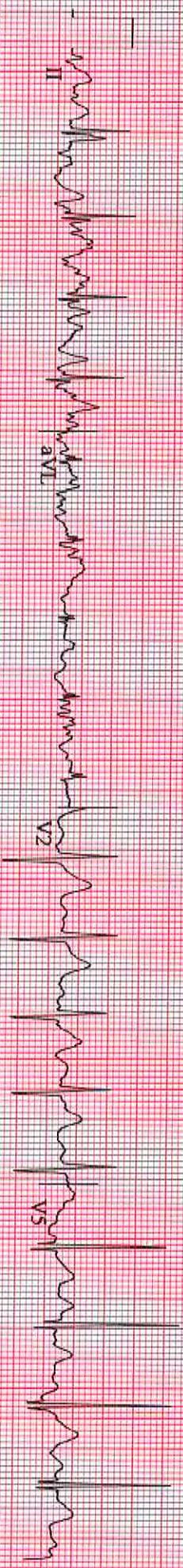
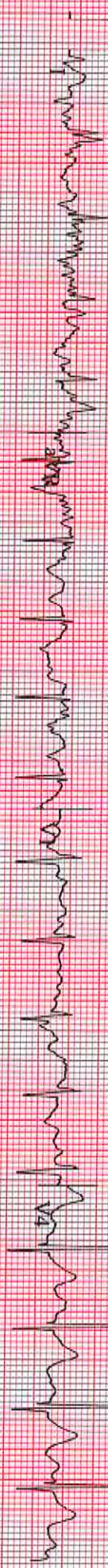
112 bpm
 129/74 mmHg

EXERCISE
 STAGE 2
 05:50

BRUCE
 4.0 km/h
 12.0%

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

Lead	ST(mm)	Lead	ST(mm)
I	1.05	V1	0.60
II	0.95	V2	1.80
III	-0.10	V3	1.60
aVR	-0.95	V4	1.35
aVL	0.55	V5	1.20
aVF	0.45	V6	1.00



GE
 CASE V6.73
 25 mm/s 10 mm/mV 50Hz 0.01Hz FRF HR(V4,V5)

Start of Test: 13:21:13

P/N: 200908.073

Tn. Pamudi PT Inspektindo
Patient ID: 0871522
10-08-2016
13:31:55

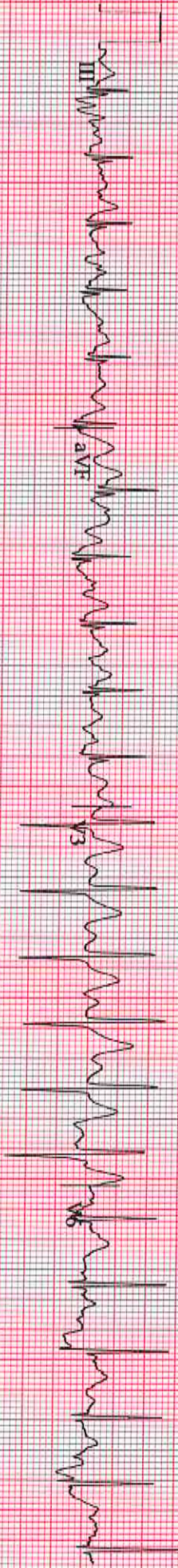
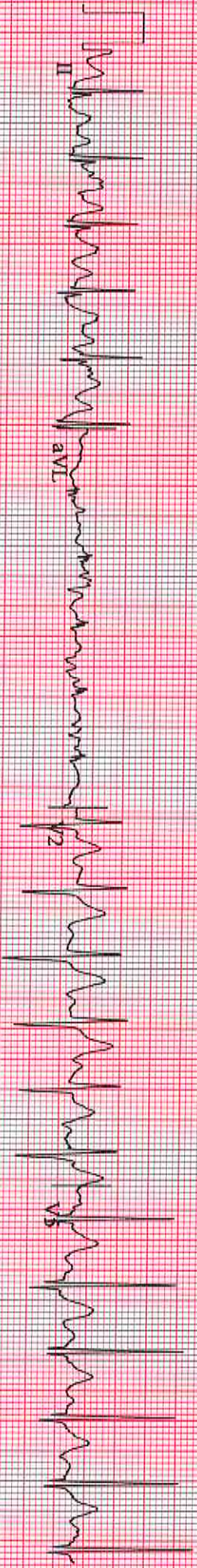
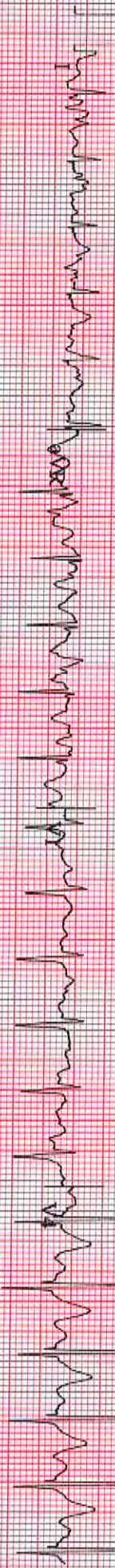
137 bpm
138.75 mmHg

EXERCISE
STAGE 3
08:50

BRUCE
5.4 km/h
14.0%

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

Lead	ST(mm)	Lead	ST(mm)
I	0.60	V1	0.65
II	0.70	V2	1.60
III	0.10	V3	1.70
aVR	-0.65	V4	1.30
aVL	0.25	V5	1.00
aVF	0.35	V6	0.30



GE
CASE V673

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

Start of Test: 13:21:13

Pt: ambudi PT. Inspektando
Patient ID: 871522
10/08/2011
13:34:55

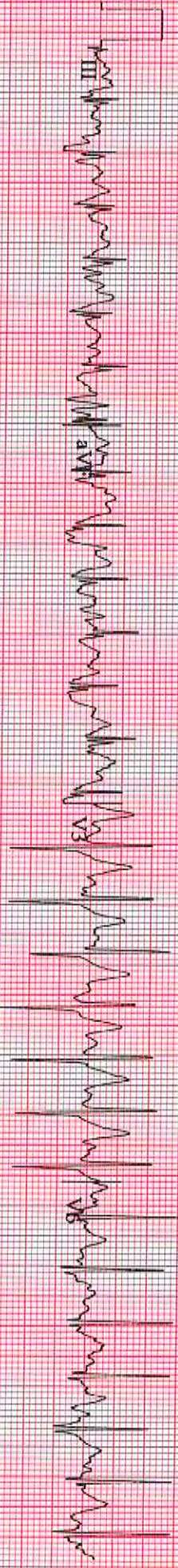
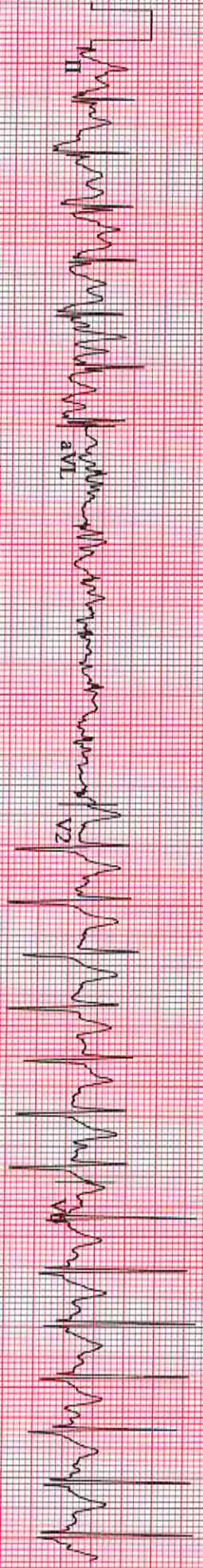
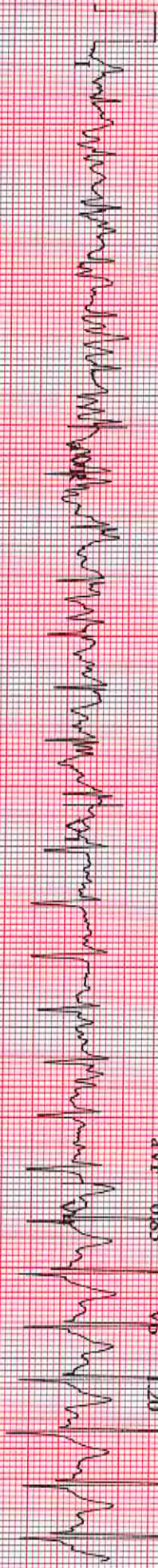
171 bpm
164/101 mmHg

EXERCISE
STAGE 4
11:50

BRUCE
6.6 km/h
16.0 %

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

Lead	ST(mm)	Lead	ST(mm)
I	1.15	V1	0.55
II	1.40	V2	2.40
III	0.30	V3	2.60
aVR	-1.25	V4	2.05
aVL	0.40	V5	1.50
aVF	0.85	V6	1.20



GE
CASE V673
25 mm/s 10 mm/mV 50Hz 0.01Hz FRF HR(V4V5)

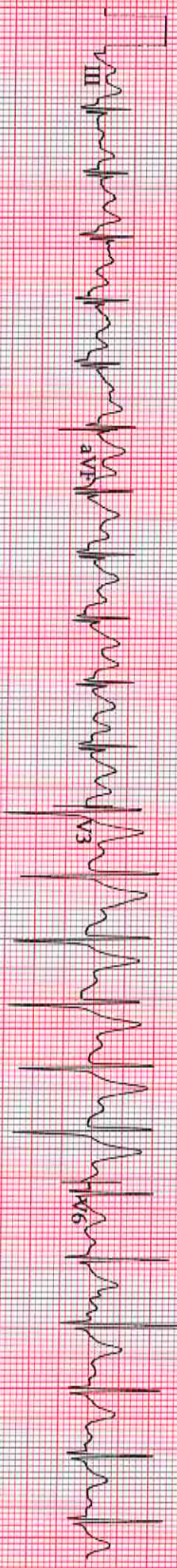
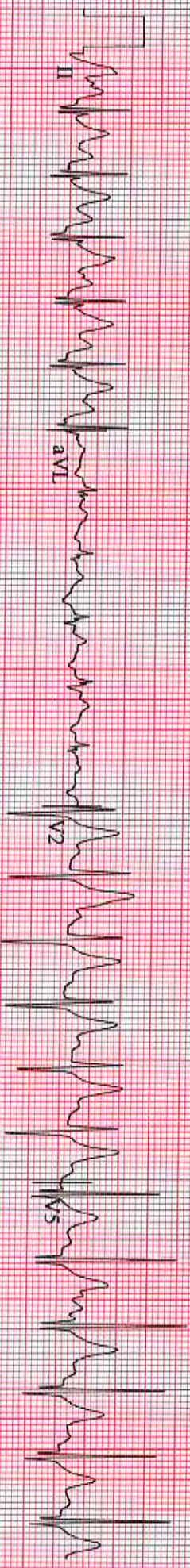
Start of Test: 13:21:13

In. Pambudi. PT. Inspektindo
 Patient ID: 0871522
 10-08-2016
 13:35:56

142 bpm
 122/56 mmHg
 RECOVERY #1
 00:50
 BRUCE
 2.4 km/h
 0.0 %

Sheam H. M. S. H. A. P. J.
 Measured at 60ms (RS-1) (1) - m.m.V.
 Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	1.40	V1	0.80
II	2.70	V2	3.60
III	1.30	V3	3.95
aVR	-2.05	V4	3.20
aVL	0.05	V5	2.45
aVF	2.00	V6	1.45



Patient Name	: PAMBUDHI KRISTYANTOTN	Patient ID	: 087152
Sex / Age	: M / 35Y 24D	Accession No.	: 2016081010059001
Modality	: CR	Report Date/Time	: 10-08-2016 09:34:11
Procedure	: THORAX AP, PA	Referring Physician	: LINDA ULI NATALISA, dr
Ref. Department	: REGISTRASI		

XR- Chest PA view

Temuan:

PARU: Normal
 TRAKEA: Normal
 KARINA: Normal
 BRONKUS UTAMA KANAN DAN KIRI: Normal
 PLEURA: Normal
 JANTUNG: Normal
 BATAS JANTUNG KANAN: Normal
 BATAS JANTUNG KIRI: Normal
 PULMONARY BAY: Normal
 HILUS: Normal
 AORTA: Normal
 VERTEBRA THORAKAL : Normal
 TULANG-TULANG YANG TERVISUALISASI : Normal
 JARINGAN LUNAK: Normal
 DIAFRAGMA: Normal
 ABDOMEN YANG TERVISUALISASI: Normal
 LEHER YANG TERVISUALISASI: Normal

Kesan:

Tidak terdapat kelainan pd CXR

Cor & Pulmo : Normal

Salam Sejawat,



dr. Santoso Suhendro. Sp. Rad (K)

10-08-2016 09:34:11

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

Patient Name	: PAMBUDHI KRISTYANTO TN	Patient ID	: 087152
Sex / Age	: M / 35Y 24D	Accession No.	: 2016081010059002
Modality	: US	Report Date/Time	: 10-08-2016 10:48:10
Procedure	: UPPER ABDOMEN USG	Referring Physician	: LINDA ULI NATALISA, dr
Ref. Department	: REGISTRASI		

US- Abdomen and Pelvis - Male

Temuan:

HEPAR: Normal

LIEN: Normal

SISTEM VENA PORTA: Normal

VENA CAVA INFERIOR, VENA HEPATIKA: Normal

SISTEM BILIER : Normal

KANDUNG EMPEDU: Tampak batu, multiple, kecil-kecil setidaknya empat (4) buah. AS (-)

PANKREAS: Normal

GINJAL D/S : Normal

Kesan:

1. Cholelithiasis, multiple (batu kolesterol)
2. Organ Intra Abdominal lainnya – Normal

Salam Sejahtera,



dr. Santoso Suhendro. Sp. Rad (K)

10-08-2016 10:48:10

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