

RAHASIA



PT. Inspektindo Sinergi Persada

HEALTH AND MEDICAL CHECK UP

No. 0026/MCU-SHBP/IX/2018

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

Tanggal MCU : 12 September 2018

Dilakukan oleh : dr. Linda Uli Natalisa
dr. Santoso Suhendro, Sp. Rad
dr. Christiani Muljono, Sp. JP
dr. Agustinus Sony Yudianto, Sp.
dr. Rizqa Kharisma, Sp. P

Jl. MT Haryono Dalam No. 23 RT. 30 Kel. Damai Kec. Balikpapan Selatan
Telp. 0542 -8862999 Fax. 0542 - 7206570
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website: <http://www.siloamhospitals.com>

RAHASIA

HEALTH AND MEDICAL CHECK UP

No. 0026/MCU-SHBP/IX/2018

Kepada : Pambudhi Kristyanto, Tn Umur/ Tanggal 37 tahun 18 Jul 1981 Male
Dept : PT. Inspektindo Sinergi Persada

Berikut adalah hasil pemeriksaan Medical Check Up yang telah dilaksanakan pada tanggal **12 September 2018**

TEMUAN 1. Gigi : Missing, calculus, caries.

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. Stop merokok.
2. Menjaga kebersihan gigi dan mulut, kontrol ke Dokter Gigi untuk perawatan.

Berlaku : **12 September 2019**

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	. Inspektindo Sinergi Persa
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I. GENERAL CONDITION

Blood Pressure (mmHg)	110/70	Pulse (x/mnt)	86	Respiration (x/mnt)	20	Temp (°C)	0
Weight (kg)	63	Height (cm)	162	BMI (kg/m²)	24.01	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		Missing, 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	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,vibrate)/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			
Distant	6/6	6/6	-	-		<input type="checkbox"/>	Normal
Near	20/20	20/20	-	-		<input type="checkbox"/>	Red - Green Absent
						<input type="checkbox"/>	Colour Blind
Visual fields (normal > 70°)			Left	-		Right	-
COMMENT :							

II. LABORATORIUM SUMMARY

<input checked="" type="checkbox"/> Normal	COMMENT :	Dalam batas normal
<input 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	4	85	%
FVC	4	3	72	%
FEV1	3	3	74	%
FEV1/FVC	81	71	88	%
COMMENT : Dalam batas 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 :	Dalam batas normal
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MCU

Medical Check Up

No. Rekam Medis : _____
Nama : PAMBUDIHI KRISTYANTO
Perusahaan : INSPEKTINDO SINERGI PERSADA
Jabatan / Posisi : INSPEKTOR
Tanggal MCU : 12 / 09 / 2018

Medical Check Up Department

HEALTH SURVEILLANCE

Isilah formulir ini dengan sebenarnya dan selengkap-lengkapnnya. Apabila ada hal-hal yang kurang dipahami segera hubungi dokter atau perawat

IDENTITAS PEGAWAI

- 1. Posisi : INSPECTOR
- 2. Status : (1) Belum Kawin (2) Kawin (3) Janda (4) Duda (5) Cerai
- 3. Jumlah anak : Anak laki-laki : 1 Orang, Anak Perempuan : 1 Orang
- 4. Alamat sekarang : Jl. TELASOREJO No.35 RT. 29 KELURAHAN TELAGASAR
BALIKRAPAN KOTA
Telpon : (0542) 425489
- 5. No. Extension Telpon. : Kantor : Kamar (untuk lapangan) :

HANYA UNTUK CALON KARYAWAN : RIWAYAT PEKERJAAN

No	Posisi	Lama kerja	Perusahaan	Lama paparan dalam jam/hari					
				Bising	Kimia	Debu	Radiasi	Ergonomi	Lain-tain
1	INSPECTOR (ASST)	6thn	FRANKLIN		2				
2	INSPECTOR	6thn	INSPEKTANDO		2				

HANYA UNTUK KARYAWAN : RIWAYAT PEKERJAAN

Tuliskan lama kerja pada masing-masing tempat kerja yang sesuai dengan posisi anda. Jumlah jam harus sesuai dengan lama kerja anda dalam sehari.

- 1. Office : jam/hari
- 2. Warehouse : 3 jam/hari
- 3. Workshop : 8 jam/hari
- 4. Process area : jam/hari
- 5. Well/Offshore : jam/hari

PETUNJUK PENGISIAN : ISILAH NOMOR YANG SESUAI DENGAN JAWABAN ANDA PADA KOTAK JAWABAN YANG TELAH TERSEDIA DISAMPING KANAN. JANGAN MELINGKARI ATAU MENCORET PILIHAN JAWABAN

RIWAYAT KESEHATAN

1. Selama 1 tahun terakhir ini, apakah anda pernah sakit :

- a. Tekanan darah tinggi 1. Ya 2. Tidak 2
- b. Tekanan darah rendah 1. Ya 2. Tidak 2
- c. Jantung 1. Ya 2. Tidak 2
- d. Stroke 1. Ya 2. Tidak 2
- e. Kencing Manis 1. Ya 2. Tidak 2

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 tangsung 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 dlm 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

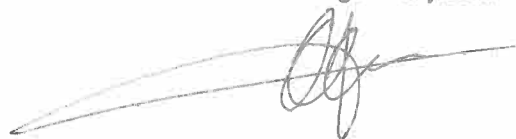
DONOR DARAH

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

02. Kapan Anda melakukan donor darah terakhir ? / /

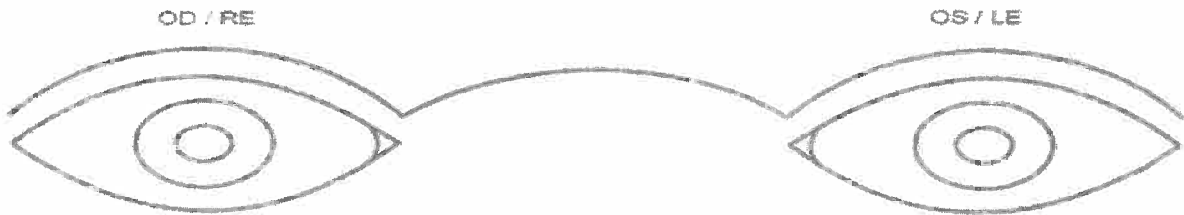
Formulir tersebut diatas telah saya isi dengan benar dan sesungguhnya

Balikpapan, 12 September 2018
Nama dan tanda tangan karyawan



(BAMBANG KRISTANTO)

SH <input type="text"/>	MR : 087152
FORMULIR PEMERIKSAAN MATA EYE EXAMINATION FORM	Name : PAMBUDHI KRISTYAI
	Sex : M
	DoB : 1981/07/18
	Ward : Out Patient



Mata Kanan (Right Eye)	Parameter	Mata Kiri (Left Eye)
<i>6/6</i>	Visus (Visual acuity)	<i>6/6</i>
	Koreksi (Correction)	
<i>20/20</i>	Adisi (Addition)	<i>20/20</i>
	Gerakan Bola Mata (Eye movement)	
	Kesegaran (Alignment)	
	Kelopak Mata (Eyelid)	
	Konjungtiva (Conjunctiva)	
	Kornea (Cornea)	
	Bilik Mata Depan (COA)	<i>normal</i>
<i>normal</i>	Pupil	
	Iris	
	Lensa (Lens)	
	Vitreous	
	Fundus	
<i>14</i>	TIO	<i>14</i>
	Lapang Pandang (Visual field)	
	Persepsi Warna (Color perception)	

Kesimpulan *ODC Embropia*

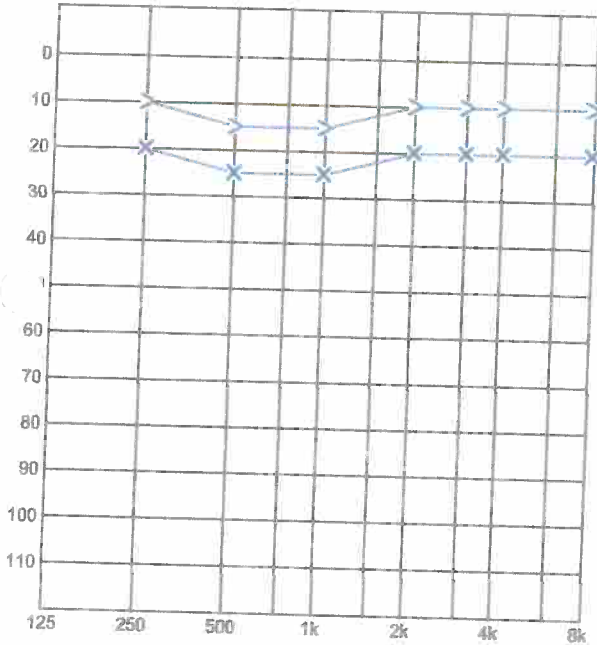
BAN2018

[Signature]
 Nama dokter & tanda tangan
 Doctor's name & signature

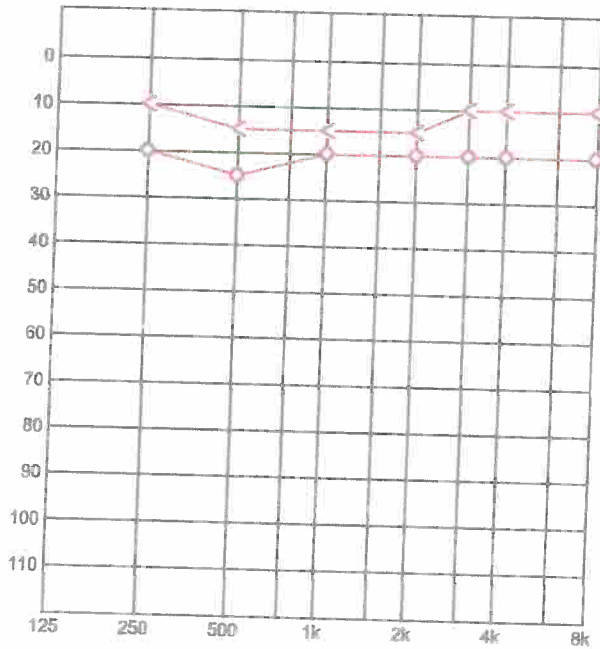
SH 	MR : 087152
HASIL PEMERIKSAAN AUDIOMETRI AUDIOMETRY REPORT	Name : PAMBUDHI KRISTYANTO.TN
	Sex : M
	DoB : 1981/07/18
	Ward : Out Patient

No. Rekam Medik (Medical Record)

Left Ear PTA 23 dBHL



Right Ear PTA 22 dBHL



Telinga Kanan

Frekuensi	250	500	1000	2000	3000	4000	6000	8000	Rata-rata
AC (dB)		25	20	20		20			21,25
BC (dB)									

Telinga Kiri

Frekuensi	250	500	1000	2000	3000	4000	6000	8000	Rata-rata
AC (dB)		25	25	20		20			22,5
BC (dB)									

Kesimpulan (Conclusion)

AV : 21,25 dB }
 BS : 22,5 dB } *terasa normal hearing*

Rekomendasi (Recommendation)

Beberapa keluhan

km. 12/9 20 *cd.*

[Signature]

Nama dokter & tanda tangan
 Doctor's name & signature

SH

HASIL PEMERIKSAAN SPIROMETRI
SPIROMETRY REPORT

No. Rekam Medik (<i>Medical Recc</i>)	MR : 087152
Nama (Name)	Name : PAMBUDHI KRISTYANTO, TN
Jenis Kelamin (Sex)	Sex : M
Usia (Age)	DoB : 1981/07/18
Tinggi Badan (<i>Height</i>)	Ward : Out Patient
Berat Badan (<i>Weight</i>)	3719
Perusahaan (<i>Company</i>)	162 cm
	63 kg
	USP

ANAMNESIS

Keluhan (*Complaint*) _____

Kebiasaan Merokok (*Smoking*) _____

Riwayat Asthma (*Asthma*) _____

Parameter	Pengukuran (<i>Measurement</i>)	Prediksi (<i>Predicted</i>)	% Prediksi (<i>% Predicted</i>)
VC	3550	4200	85%
FVC	3150	4030	78%
FEV ₁	2770	3400	81%
FEV ₁ / FVC	87.90	80.60	109%

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

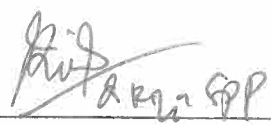
Kesimpulan (*Conclusion*)

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

Kesimpulan
Normal Spirometri

Rekomendasi (*Recommendation*)

.....20



Nama dokter & tanda tangan
Doctor's name & signature

Patient Name : PAMBUDHI KRISTYANTO, TN
 Address : JL.TELOGO REJO NO 35 RT 29
 Age : 37 Thn 1 Bin 25 Hr
 DOB/Sex : 18-07-1981 / Male
 Ward : CHECKUP /
 Physician : dr. Linda Uli Natalisa
 MR. No. : SHBP.00087152
 Clinical Info :

Order Time : 12-09-18 08:11
 Specimen Received : 12-09-18 08:15
 Print Out : 12-09-18 19:53
 Lab No. : 18026846 /
 Patient Category : INSPEKTINDO
 Reg. No. : CPA1809120002
 Page : 1 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
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HAEMATOLOGY

Hematologi Lengkap

Hemoglobin	14.9	g/dL	14.0 - 18.0	
Jumlah Lekosit	5.39	10 ³ /ul	4.50 - 11.50	
litung Jenis				
Eosinofil	3	%	1 - 3	
Basofil	0	%	0 - 2	
Neutrofil Segmen	54	%	50 - 70	
Limfosit	33	%	18 - 42	
Monosit	10	%	2 - 11	
Hematokrit	46.0	%	40.0 - 54.0	
Jumlah Trombosit	234	10 ³ /ul	150 - 450	
Jumlah Eritrosit	5.25	10 ⁶ /uL	4.60 - 6.00	
MCV, MCH, MCHC				
MCV	87.6	fL	80.0 - 94.0	
MCH	28.4	pg	26.0 - 32.0	
MCHC	32.4	g/L	32.0 - 36.0	
Laju Endap Darah 1 jam	4	mm	0 - 13	

CLINICAL CHEMISTRY

SGOT - SGPT

SGOT	20.8	U/L	<37	
SGPT	19.5	U/L	<45	
Gamma GT	31.0	U/L	8-61	
Trigliserida	79	mg/dL	Normal: <150 mg/dL Borderline High: 150-199 mg/dL High: 200-499 mg/dL Very high: >= 500 mg/dL	
Kolesterol Total	188	mg/dL	Desirable: <200 mg/dL Borderline High: 200-239 mg/dL High: >= 240 mg/dL	
HDL Kolesterol	48	mg/dL	Major risk: <40 mg/dL Negative risk: >= 60 mg/dL	

Patient Name : PAMBUDHI KRISTYANTO, TN
 Address : JL. TELOGO BEJO NO 35 RT 20
 Age : 37 Ths 1 Bln 25 Hr
 DOB/Sex : 18-07-1981 / Male
 Ward : CHECKUP
 Physician : dr. Linda Wli Natalia
 MR. No. : SHBP.00087152
 Clinical Info :

Order Time : 12-09-18 08:11
 Specimen Received : 12-09-18 08:15
 Print Out : 12-09-18 19:53
 Lab No. : 18026846
 Patient Category : INSPEKTINDO
 Reg. No. : CPA1809120300
 Page : 2 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
LDL Kolesterol	136	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	
Leukosa Darah Puasa	93	mg/dL	76 - 100	
Ureum Darah	18.1	mg/dL	<50	
Kreatinin Darah	0.85	mg/dL	0.70 - 1.20	
Asam Urat	6.5	mg/dL	3.4 - 7.0	
SEROLOGY				
HBsAg Rapid	Non Reaktif		Non Reaktif	
URINALISYS				
Urin Lengkap				
Makroskopis				
Warna	Kuning		Kuning	
Kejernihan	Jernih		Jernih	
Berat Jenis	1.020		1.016 -1.022	
pH	5.0		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	0-2	/lpb	1 - 5	
Eritrosit	0-2	/lpb	0 - 1	
Silinder	Negatif			
Sel Epitel	0-2	/lpk	0 - 2	

Patient Name : **PAMBUDHI KRISTYANTO, TN**
 Address : **JL.TELOGO REJO NO 35 RT 29**
 Age : **37 Thn 1 Bln 25 Hr**
 DOB/Sex : **18-07-1981 / Male**
 Ward : **CHECKUP**
 Physician : **dr. Linda Oli Natalisa**
 IPF. No. : **CHEP.00087132**

Order Time : **12-09-18 08:11**
 Specimen Received : **12-09-18 08:15**
 Print Out : **12-09-18 19:53**
 Lab No. : **18026846**
 Patient Category : **INSPEKTINDO**
 Reg. No. : **CPA1809120002**
 Page : **1 / 3**

Clinical Info :

RUTIN

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

STOOL

Faeces Rutin

Makroskopis

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

Mikroskopik

Leukosit	0-1	/ipb	0 - 1
Eritrosit	0-2	/ipb	0 - 1
Parasit	Negatif		Negatif
Telur Cacing	Tidak Ditemukan		Negatif

Clinical Pathologist

dr. Yuly Eko P., M.Kes., Sp.PK.

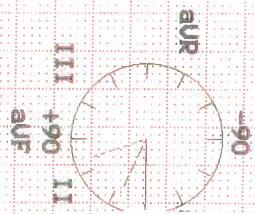
Authorized By Rina S

Authorisation Date : 12-09-18 19:53

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

Measurement Results:

QRS : 94 ms
 QT/QTcB : 370 / 445 ms
 PR : 162 ms
 P : 114 ms
 RR/PP : 690 / 685 ms
 P/QRS/T : 70 / 0 / 25 degrees
 QTd/QTcBd : 38 / 46 ms
 Sokolow : 2.2 mV
 NK : 12



Interpretation:

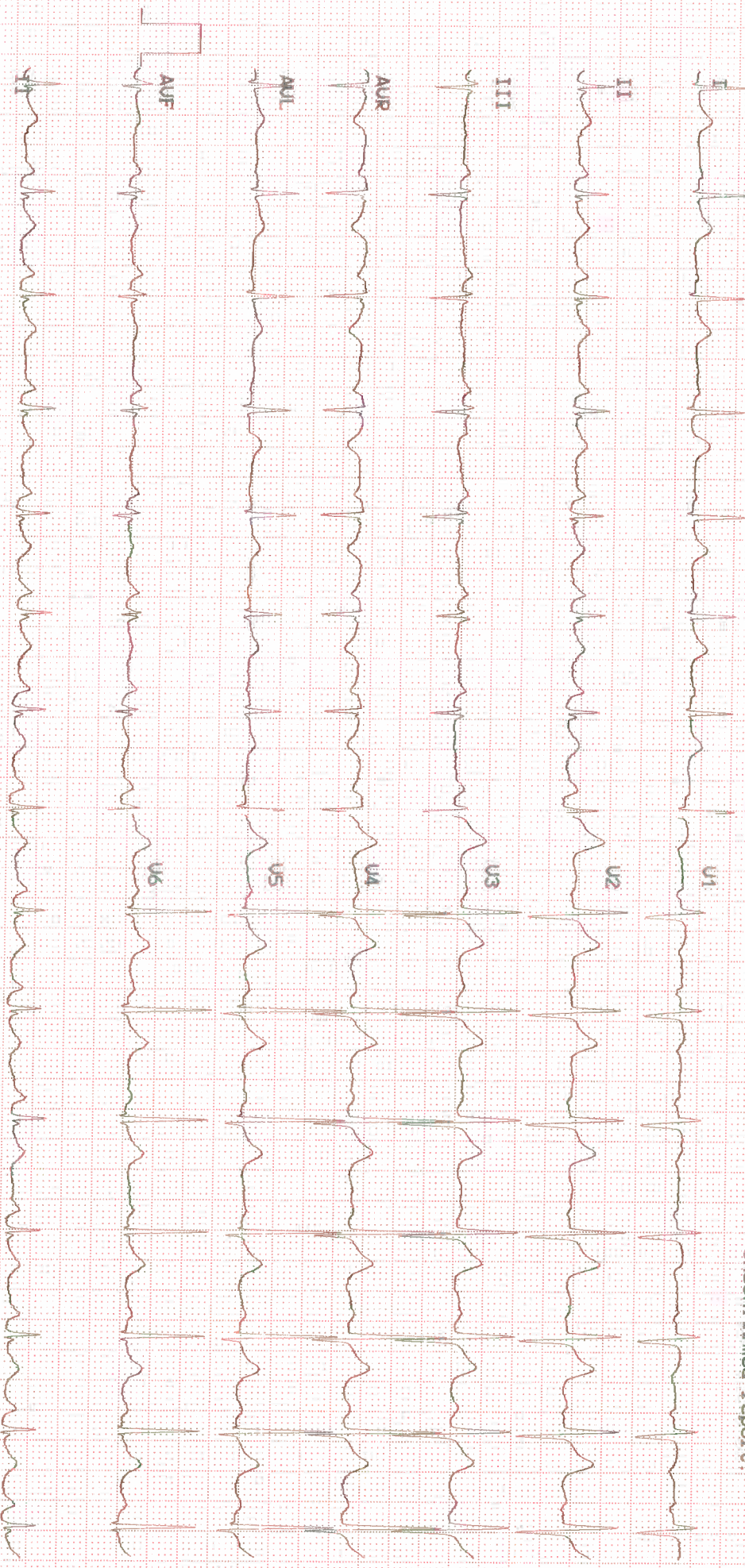
MR : 087152
 Name : PAMBUDHI KRISTYANTO, TN
 Sex : M
 DOB : 1981/07/18
 Ward : Out Patient

1 and U2

NSR

[Signature]

Unconfirmed report.



**TREADMILL EXERCISE TEST
(PROTOKOL BRUCE)**

Nama : Tn. Pambudhi K Tanggal Treadmill : 12 September 2018
Umur : 37 thn Berat : 63 kg
Jenis Kelamin : Laki - Laki Tinggi : 162 cm
Perusahaan : Inspektindo, PT Tekanan Darah Awal : 102/62 mmHg

❖ Lama test : 10 Menit 26 Detik
❖ Denyut Jantung maksimal : 173x/menit (94% MHR)
❖ Tekanan darah maksimal : 128/61 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 : 10.26 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. Christiani Muljono, Sp. JP
Siloam Hospitals Balikpapan

Patient ID: 08.71.52

12.09.2018 Male 167 cm 63 kg

13.14.15 37yrs Asian

Meds:

Test Reason:

Medical History:

Ref. MD: Ordering MD:

Technician: Ika Test Type:

Comment:

PRUICE: Total Exercise Time 10:26
 Max HR: 173 bpm 94% of max predicted 183 bpm HR at rest: 74
 Max BP: 128/61 mmHg BP at rest: 102/62 Max RPP: 14976 mmHg*bpm
 Maximum Workload: 13.30 METS
 Max. ST: 0.35 mm, 0.00 mV/s in II EXERCISE STAGE 4 09:29
 Arrhythmia: A:3
 HR reserve used: 89 %
 HR recovery: 28 bpm
 Freq VE recovery: 0 VE/min
 ST/HR hysteresis: 0.049 mV (I)
 QRS duration: BASELINE: 82 ms, PEAK EX: 78 ms, REC: 86 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 (l mm)	Comment
PRETEST	SUPINE	00:01	0.00	0.00	1.0	78	102/62	7956	0	--	
	STANDING	00:52	0.00	0.00	1.0	80			0	0.90	
	HYPERV.	00:03	0.00	0.00	1.0	80			0	0.90	
	WARM-UP	00:58	1.60	0.00	1.6	83	101/64	8383	0	0.85	
EXERCISE	STAGE 1	03:00	2.70	10.00	4.6	100	119/58	11900	0	0.75	
	STAGE 2	03:00	4.00	12.00	7.0	125	118/59	14750	0	0.50	
	STAGE 3	03:00	5.40	14.00	10.0	141			0	0.65	
	STAGE 4	01:26	6.70	16.00	13.3	173			0	1.00	
RECOVERY		03:29	0.00	0.00	1.0	115	128/61	14720	0	0.80	

GE CASE V6.73 (0)

Uncol Timed

Attending M

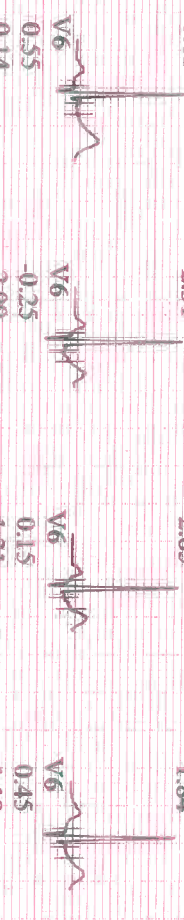
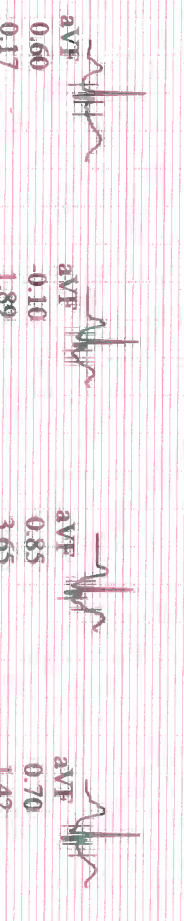
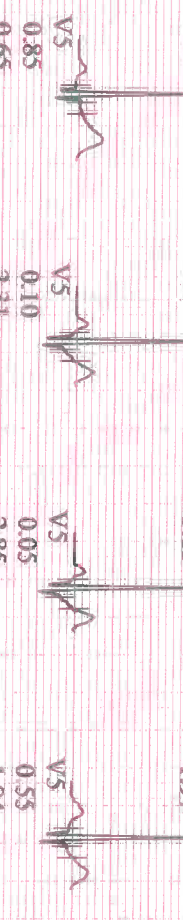
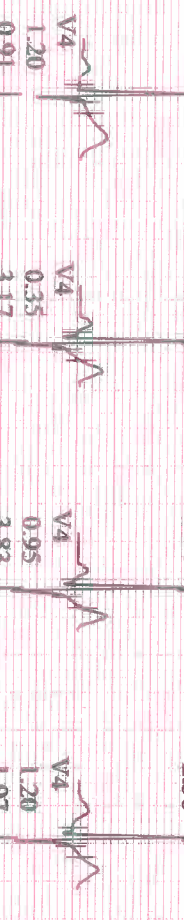
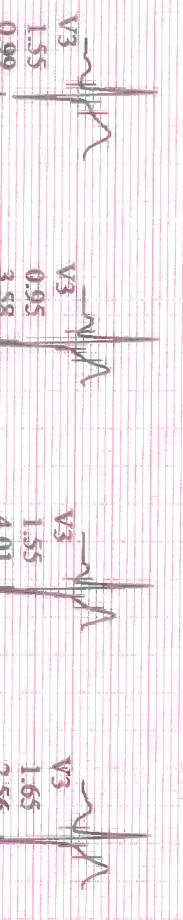
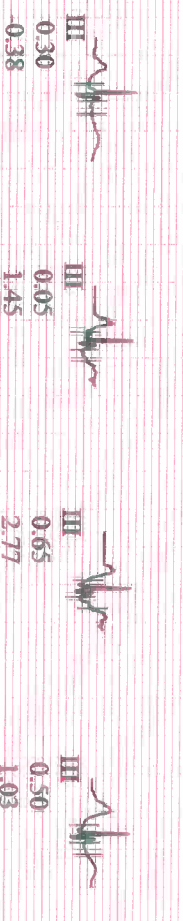
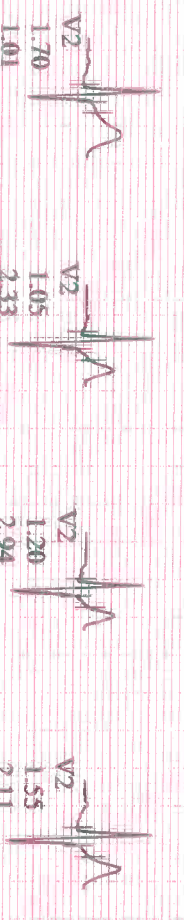
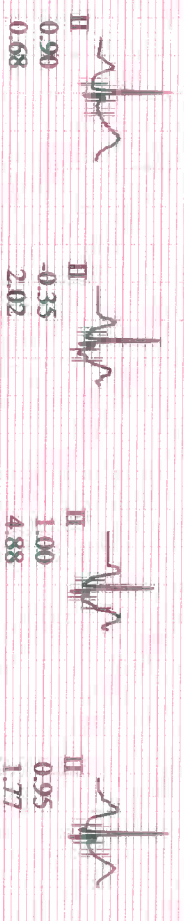
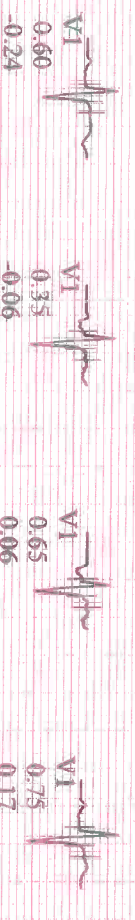
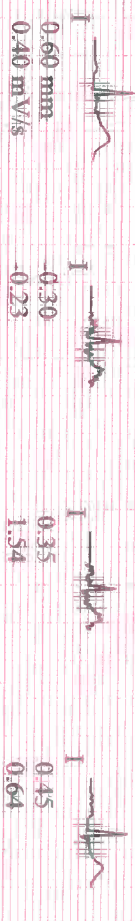
Patient ID 08.71.52

12.09.2018

13:14:15

BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE	TEST END RECOVERY
0:00 84 bpm 101/64 mmHg	9:29 164 bpm	10:26 173 bpm	3:03 118 bpm 128/61 mmHg

BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE	TEST END RECOVERY
0:00 84 bpm 101/64 mmHg	9:29 164 bpm	10:26 173 bpm	3:03 118 bpm 128/61 mmHg



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

Uncrimed

Attending MD

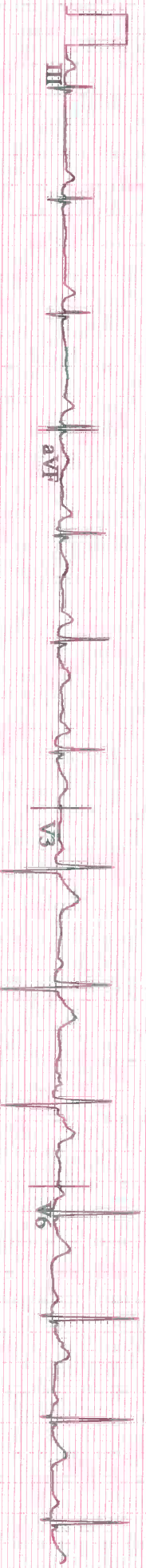
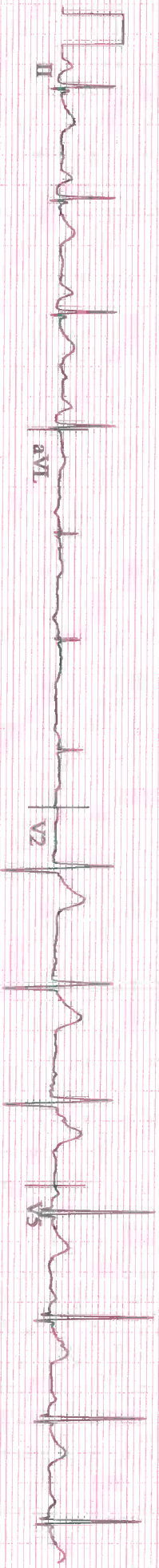
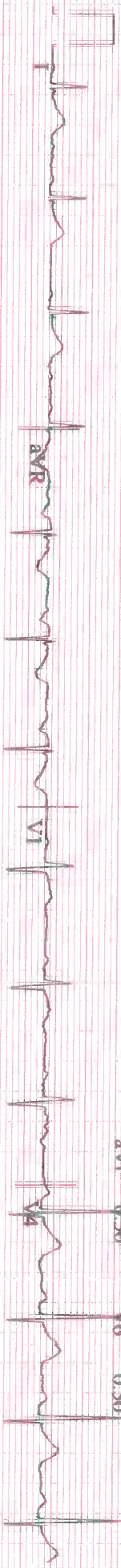
Inspektindo, PT Tn Panibudhi K
 Patient ID: 08.71.52
 12.09.2018
 13:15:04

75 bpm
 102.62 mmHg

PRE-TEST
 STANDING
 00:48
 BRUCE
 0.0 km/h
 0.0 %

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

Lead	SI(R)(mm)	Lead	SI(L)(mm)
I	0.60	V1	0.65
II	0.75	V2	1.80
III	0.20	V3	1.50
aVR	-0.65	V4	1.05
aVL	0.15	V5	0.70
aVF	0.50	V6	0.50



GE
 CASE V6.73

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

Start of Test: 13:14:15

Inspektando, PT. Ta. Paribudhi K

Patient ID: 08.71.52

12.09.2018

13:16:03

84 bpm

101.64 mmHg

PRETEST

W/ARM-UP

01:47

BRUCE

1.6 km/h

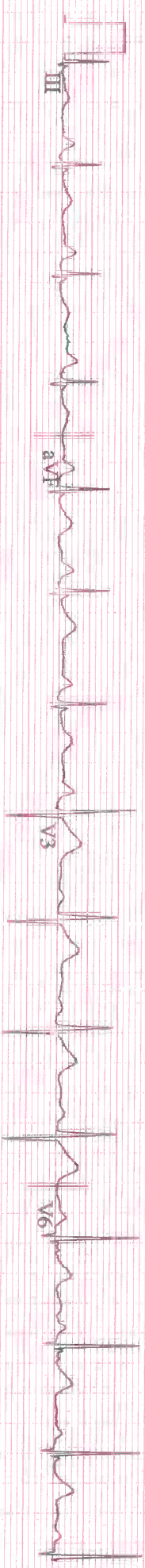
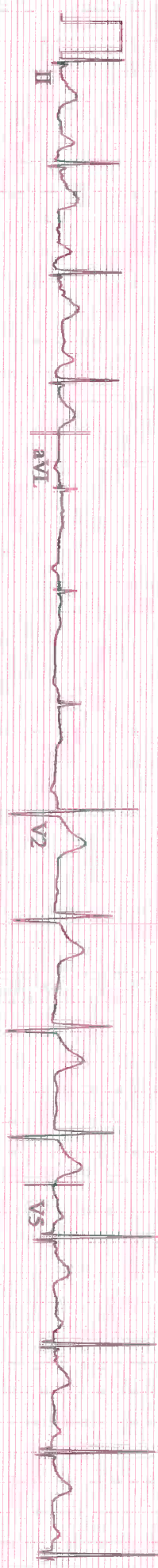
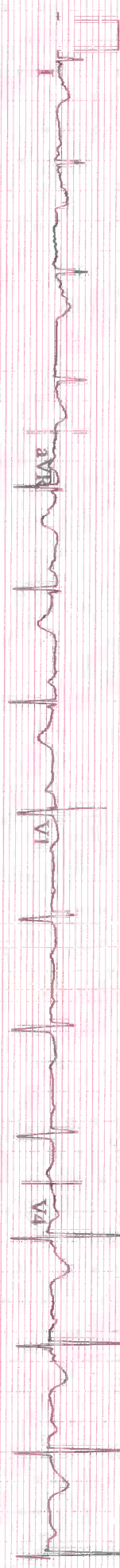
(XO)¹⁰

Siloam Hospital Balikpapan

Measured at 6cm/s Post J (10mm/mV)

Auto Points

Lead	ST _T (mm)	Lead	ST _T (mm)
I	0.55	V1	0.55
II	0.90	V2	1.75
III	0.40	V3	1.65
aVR	-0.70	V4	1.30
aVL	0.10	V5	0.95
aVF	0.65	V6	0.70



GE

CASE V6.73

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

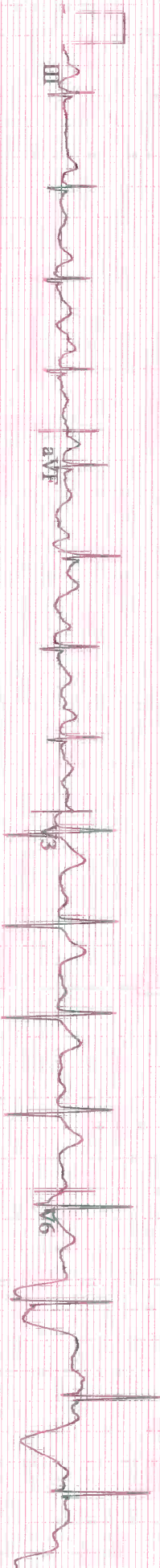
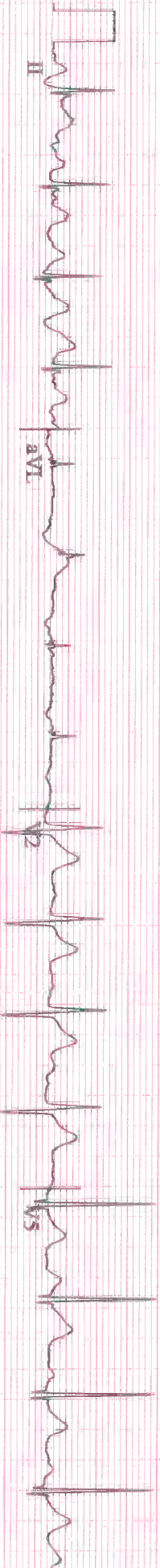
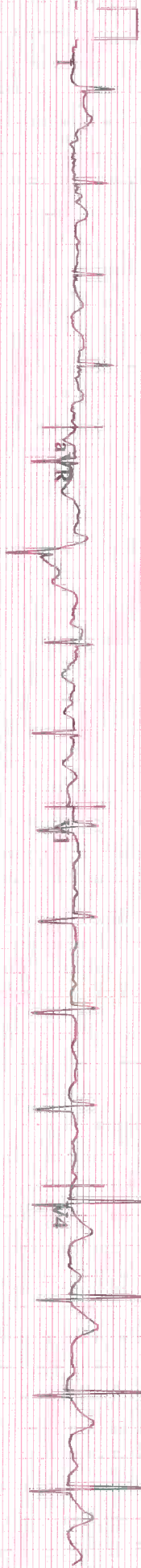
Start of Test: 13:14:15

99 bpm
119.58 mmHg

EXERCISE
STAGE 1
02:50

BRUCE
2.7 km/h
10.0%

Lead	ST(mm)	Lead	ST(mm)
I	0.65	V1	0.70
II	1.05	V2	1.45
III	0.40	V3	1.70
aVR	-0.85	V4	1.35
aVL	0.05	V5	0.95
aVF	0.80	V6	0.80



Inspektorindo, PT. Jh Panbudhi K

Patient ID: 08.71.52

12.09.2018

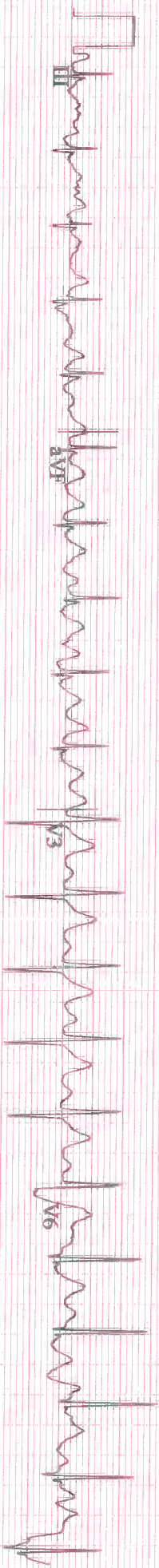
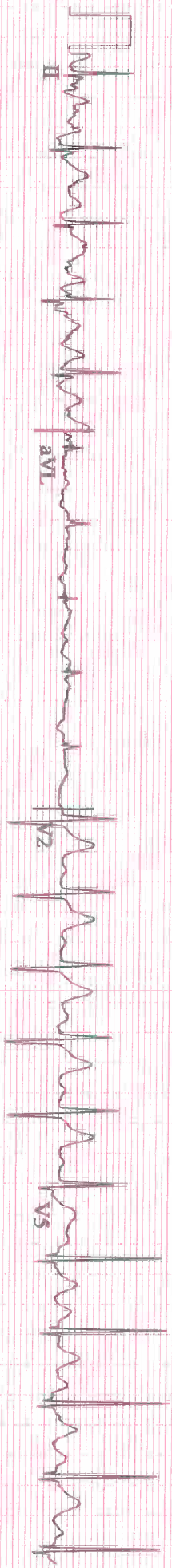
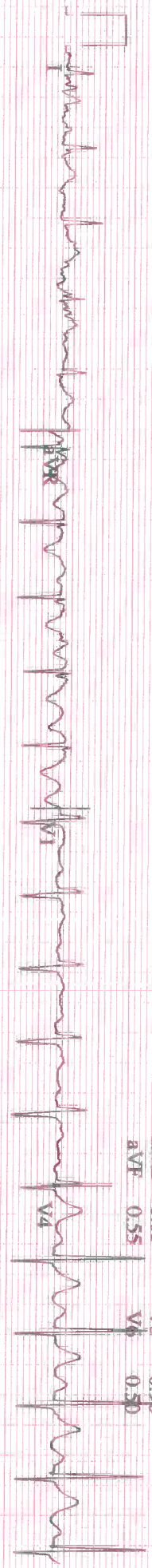
13.21.58

122 bpm
118.59 mmHg

EXERCISE
STAGE 2
05:50
BRUCE
4.0 km/h
12.0 %

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

Lead	SR (mm)	L lead	ST (mm)
I	0.45	V1	0.70
II	0.75	V2	1.55
III	0.30	V3	1.70
aVR	-0.65	V4	1.25
aVL	0.05	V5	0.90
aVF	0.55	V6	0.50



GE

CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01Hz ERF+ HRC(V5, V4)

Start of Test: 13:14:15

Inspektindo, PT Tin Panbudhi K
Patient ID: 08.71.52
12.09.2018
13:24:58

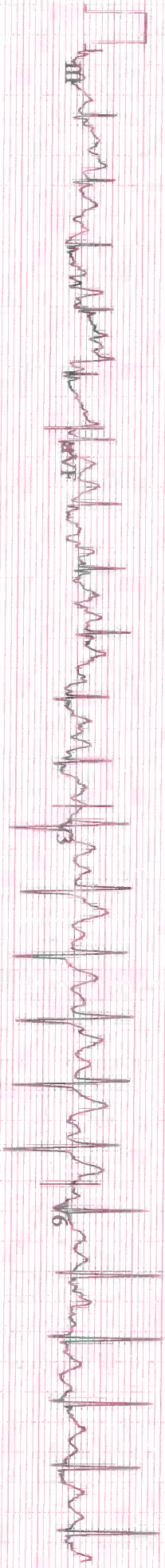
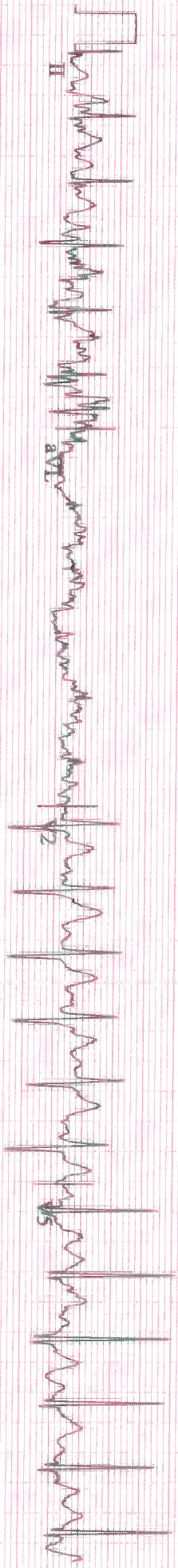
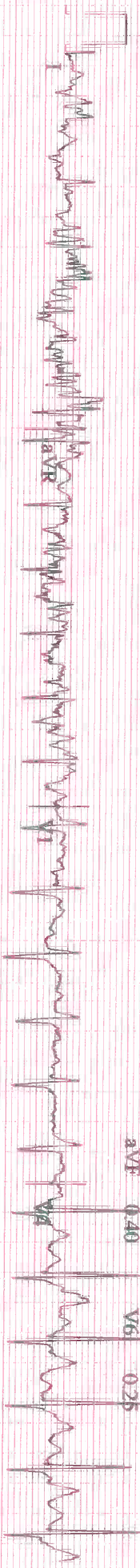
139 bpm

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	SI(kmm)	Lead	SI(kmm)
I	0.50	V1	0.60
II	0.70	V2	1.45
III	0.15	V3	1.50
aVR	-0.60	V4	1.00
aVL	0.15	V5	1.15
aVF	0.40	V6	0.25



GE
CASE V6.73

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

Start of Test: 13:14:15

BASELINE

CURRENT

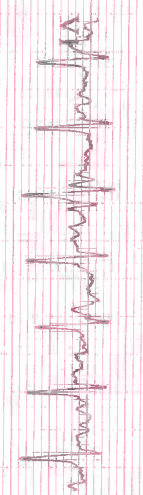
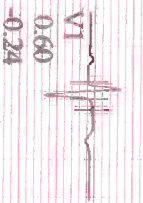
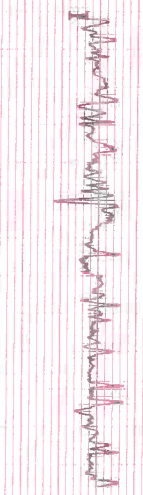
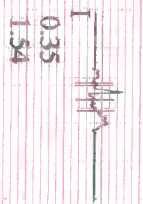
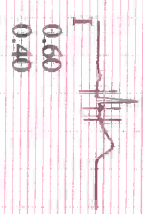
BASELINE

CURRENT

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

60 ms post J

ST @ 10mm/mV 60 ms post J

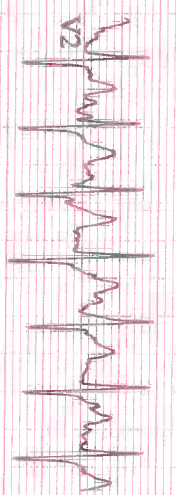
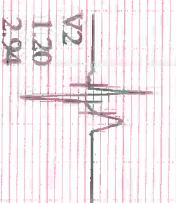
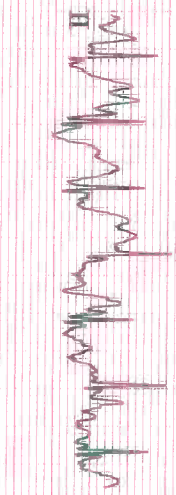
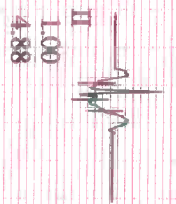


0.60
0.40

0.35
1.54

0.60
-0.24

0.65
0.06

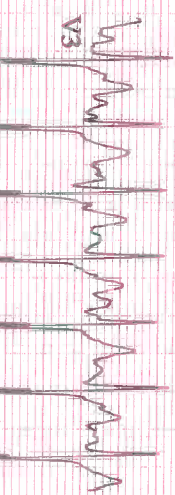
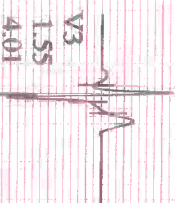
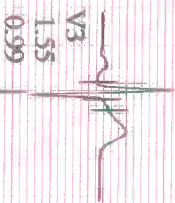
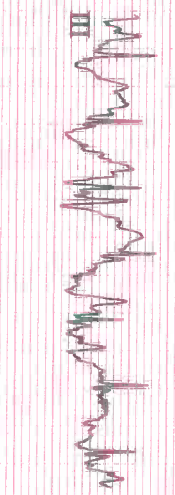
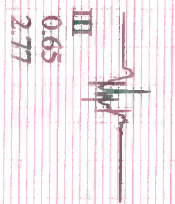
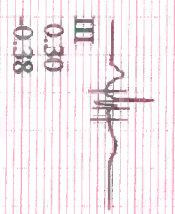


0.90
0.68

1.00
4.88

1.70
1.01

1.20
2.94

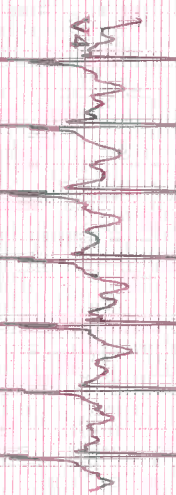
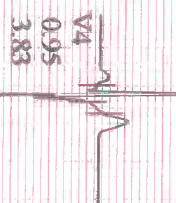
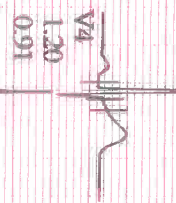
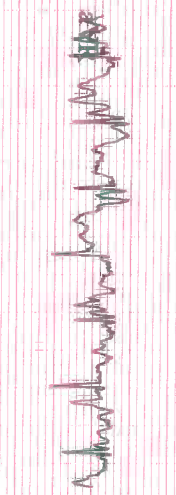
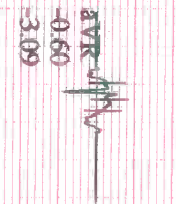
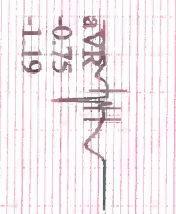


0.30
-0.38

0.65
2.77

1.55
0.99

1.55
4.01

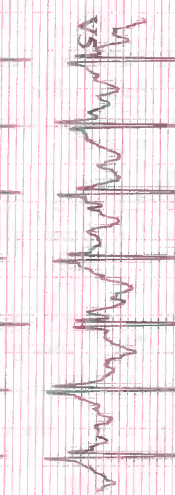
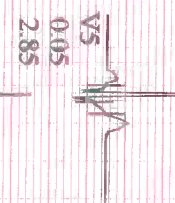
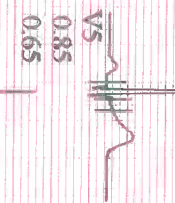
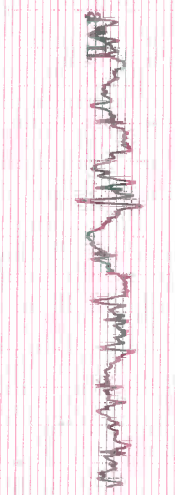
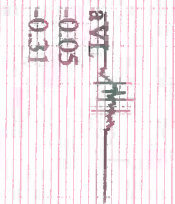
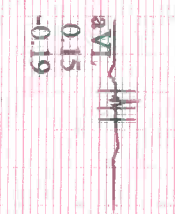


-0.75
-1.19

-0.60
-3.09

1.20
0.91

0.95
3.83

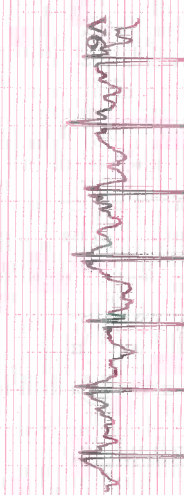
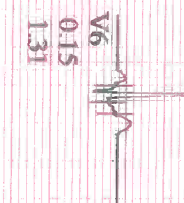
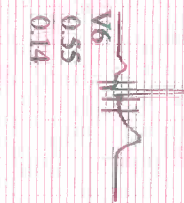
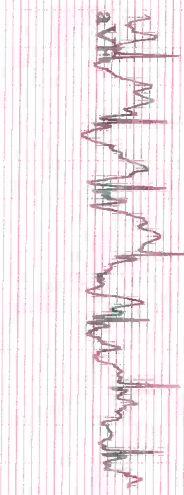
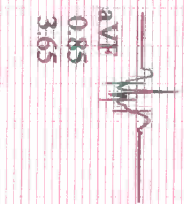
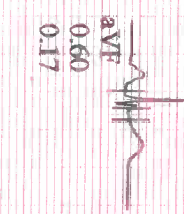


0.15
-0.19

-0.05
-0.31

0.85
0.65

0.05
2.85



0.60
0.17

0.85
3.65

0.55
0.14

0.15
1.31

GE

CASE: V6.73

25 mm/s 10 mm/mV 50Hz 0.01Hz PRF+ HR(V5 V4)

Start of Test: 13:14:15

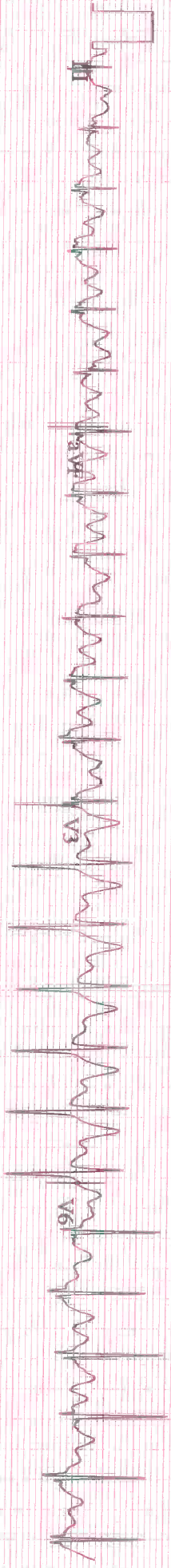
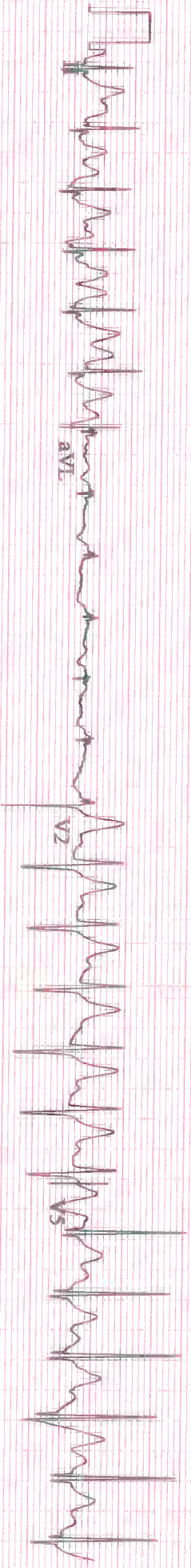
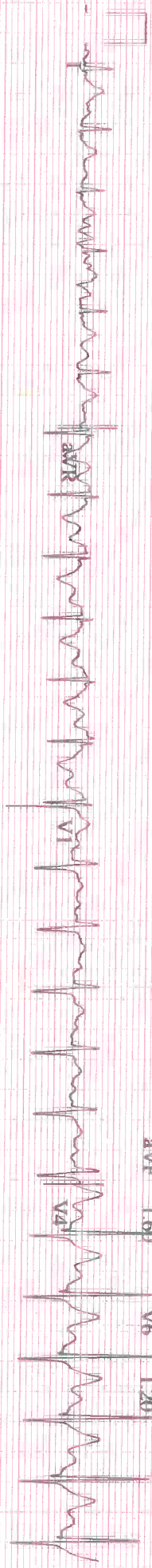
150 bpm

RECOVERY #1 00:50

BRUCE 2.4 km/h 0.0%

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

Lead	ST(mm)	Lead	ST(mm)
I	0.80	V1	1.05
II	2.00	V2	2.70
III	1.20	V3	3.10
aVR	-1.40	V4	2.40
aVL	-0.20	V5	1.45
aVF	1.60	V6	1.20



GE

CASE V6.73

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

Start of Test: 13:14:15

Inspektindo, PT In Pamudhii K

Patient ID: 08.71.52

12.09.2018

13.28.24

123 bpm

RECOVERY #1

01:50

BRUCE 2.4 km/h

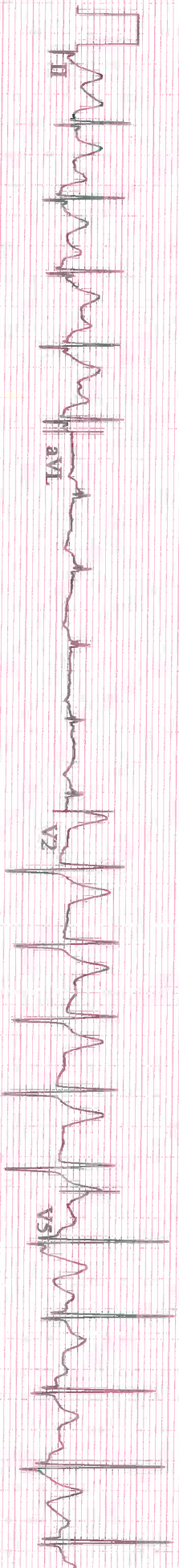
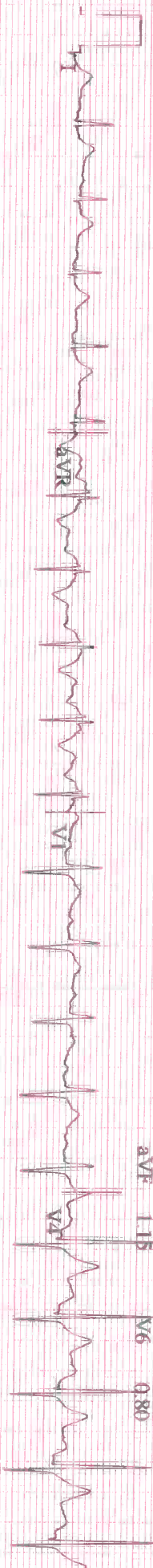
0:00.0

Siloam Hospital Balikpapan

Measured at 60ms Post J (10mm mV)

Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.60	V1	1.05
II	1.40	V2	2.35
III	0.90	V3	2.55
aVR	-1.00	V4	1.90
aVL	-0.10	V5	1.00
aVF	1.15	V6	0.80



GE

CASE V6.73

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

Start of Test: 13:14:15

Inspektando, PT In Lambudhi K
Patient ID: 08.71.52
12.09.2018
13.29.14

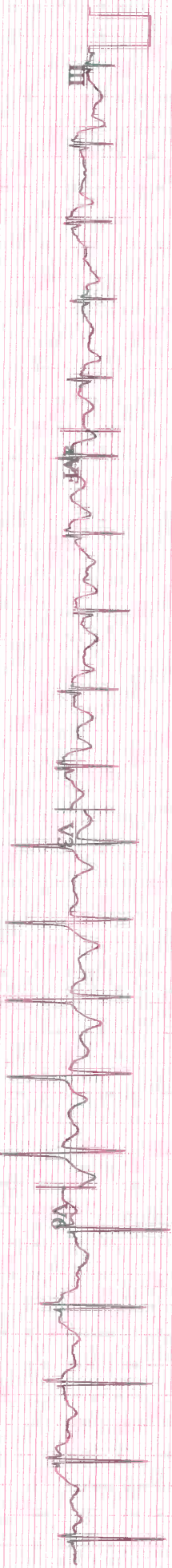
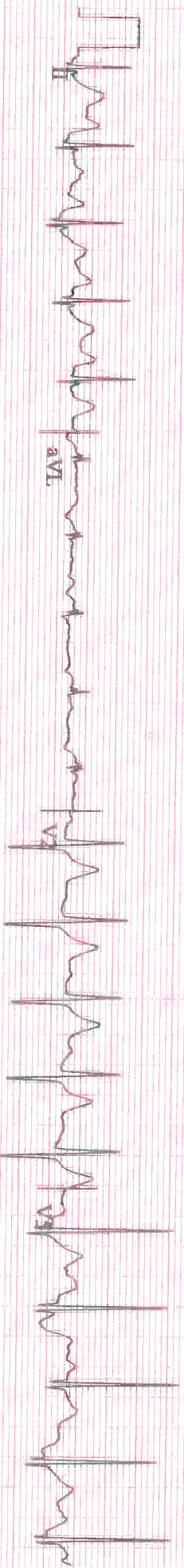
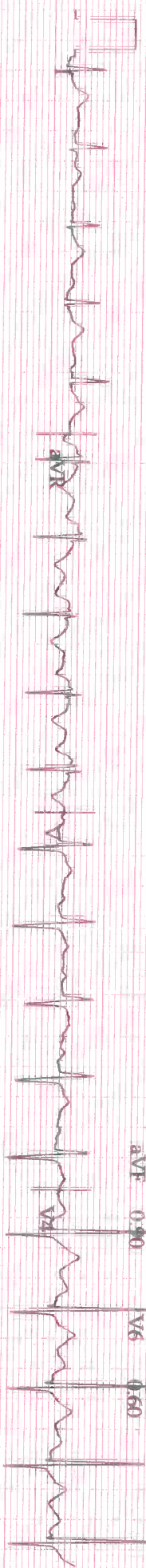
117 bpm

RECOVERY
#1
02:50

BRUCE
2.4 km/h
0.0%

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

Lead	ST(mm)	Lead	ST(mm)
I	0.55	V1	0.70
II	1.15	V2	1.70
III	0.60	V3	1.85
aVR	-0.85	V4	1.30
aVL	0.99	V5	1.00
aVF	0.90	V6	0.60



GE
CASE V673

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

Start of Test: 13:14:15

Patient Name	: PAMBUDHI KRISTYANTO, TN	Patient ID	: SHBP.00087152
Sex / Age	: M / 037Yrs	Accession No.	: 10000006689119
Modality	: CR	Scan Date	: 12-09-2018
Procedure	: THORAX AP, PA	Report Date/Time	: 12-09-2018 10:13:08
Ref. Department	: MCU	Referring Physician	: dr. Linda Uli Natalisa

XR- Thorax PA view

Technique:

Findings:

PARU: Normal
 MEDIASTINUM: Normal
 TRAKEA DAN BRONKUS: Normal
 HILUS: Normal
 PLEURA: Normal
 DIAFRAGMA: Normal
 JANTUNG: Normal CTR: <50%
 AORTA: Normal
 VERTEBRA THORAKAL DAN TULANG-TULANG LAINNYA: Normal
 JARINGAN LUNAK: Normal
 ABDOMEN YANG TERVISUALISASI: Normal
 LEHER YANG TERVISUALISASI: Normal

Impression:

Tidak tampak kelainan signifikan pada pemeriksaan ini.

dr. Santoso Suhendro. Sp. Rad (K)

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

Patient Name	: PAMBUDHI KRISTYANTO, TN	Patient ID	: SHBP.00087152
Sex / Age	: M / 037Yrs	Accession No.	: 10000006689115
Modality	: US	Scan Date	: 12-09-2018
Procedure	: UPPER ABDOMEN USG	Report Date/Time	: 12-09-2018 15:58:16
Ref. Department	: MCU	Referring Physician	: dr. Linda Uli Natalisa

US- Upper Abdomen, Male

Technique:

Findings:

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

Impression:

Pria, 37 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.