

RAHASIA



PT. Inspektindo Sinergi Persada

HEALTH AND MEDICAL CHECK UP

No. 0030/MCU-SHBP/III/2018

Nama : **Saut Halomoan S, TN**
Tanggal Lahir : **03 Juli 1981**
Jenis Kelamin : **Male**
S/N :
Jabatan / Posisi : **Inspector**

Tanggal MCU : **09 Februari 2018**

Dilakukan oleh : **dr. Linda Uli Natalisa**
dr. Santoso Suhendro, Sp. Rad
dr. Christiani Muljono, Sp. JP
dr. Rizqa Kharisma, Sp. P
dr. Maranatha Lumban Batu, Sp. T

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RAHASIA

HEALTH AND MEDICAL CHECK UP

No. 0030/MCU-SHBP/III/2018

Kepada : **Saut Halomoan S, TN** Umur/ Tanggal **37 tahun 03 Jul 1981** **Male**
Dept : **PT. Inspektindo Sinergi Persada**

Berikut adalah hasil pemeriksaan Medical Check Up yang telah dilaksanakan pada tanggal **09 Februari 2018**

- TEMUAN**
1. BMI : 30,86 kg/m (Obese).
 2. Gigi : Calculus.
 3. Spirometri : Restriksi ringan.
 4. Audiometri tes : Moderate HL AD.
 5. Laboratorium DL : MCHC, HDL menurun, trigliserida, kolesterol meningkat.
 6. Laboratorium UL : BJ menurun.
 7. EKG : Sinus bradycardia.

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. Stop merokok, Menjaga kebersihan gigi dan mulut, kontrol ke Dokter Gigi untuk perawatan.
2. Turunkan berat badan dengan cara rutin berolahraga 3 -5 x/minggu.
3. Hindari makanan tinggi karbohidrat dan tinggi kolesterol.
4. Hindari area bising dan selalu menggunakan APD jika di area berdebu dan bahan kimia.
5. Konsultasi ke Dokter Spesialis Penyakit Dalam untuk evaluasi hasil laboratorium terutama adanya dislipidemia.
6. Konsultasi ke Dokter Spesialis THT untuk evaluasi hasil audiometri test.

Berlaku : **09 Februari 2019**

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

Dokter Pemeriksa,


dr. Linda Ufi Natalisa

Medical Department

HEALTH AND MEDICAL CHECK UP

PHYSICAL EXAMINATION

Name	Saut Halomoan S, TN	S/N		DEPT	. Inspektindo Sinergi Persa
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I. GENERAL CONDITION

Blood Pressure (mmHg)	110/70	Pulse (x/mnt)	60	Respiration (x/mnt)	18	Temp (° C)	0
Weight (kg)	80	Height (cm)	161	BMI (kg/m ²)	30,86	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		Calculus
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

Saut Halomoan S, 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"/>	<input type="checkbox"/>
Near	20/20	20/20	-	-		<input type="checkbox"/>	<input type="checkbox"/>
Visual fields (normal > 70°)			Left	-		Right	-
COMMENT :							

II. LABORATORIUM SUMMARY

<input type="checkbox"/> Normal	COMMENT :	Laboratorium DL : MCHC, HDL menurun, trigliserida, kolesterol meningkat → UL : BJ menurun.
<input checked="" type="checkbox"/> Abnormal		

III. CHEST X-RAY

Pneumoconiosis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If Yes - ILO Clasification	-	
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 bradycardia
<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	4.00	2.55	64	%
FVC	3.39	2.53	75	%
FEV 1	80.7	99.2	123	%
FEV/FVC	8.49	9.35	110.	%
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 type="checkbox"/> Normal	If Yes, what change :	-	
<input checked="" 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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KEBIASAAN MEROKOK

01. Apakah Anda pernah merokok ? 1. Ya 2. Tidak
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
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
bila tidak langsung ke olahraga
02. Apakah Anda minum minuman beralkohol dalam 12 bulan terakhir ? 1. Ya 2. Tidak
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 2. Tidak 3. Tidak tahu

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

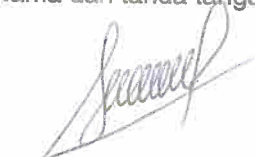
DONOR DARAH

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, 09 Februari 2018
Nama dan tanda tangan karyawan

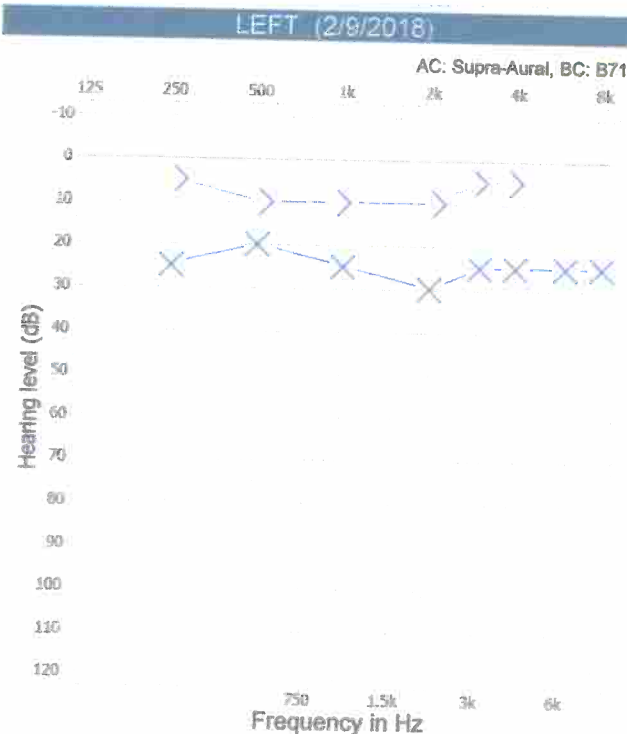
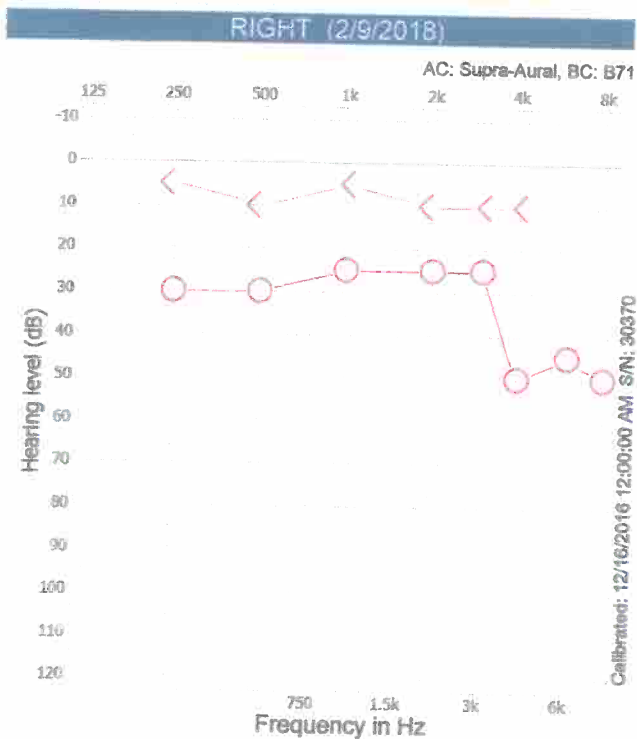

(SAUT HALIMAH.S)

SH

HASIL PEMERIKSAAN AUDIOMETRI
AUDIOMETRY REPORT

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

MR : 058436
 Name : SAUT HALOMOAN.S SEMBIRING, TN
 Sex : M
 DoB : 1981/07/03
 Ward : Out Patient



Legend

L	R	Masked
X	O	□ △
>	<	□ □
S	S	※ ⊗
M	M	
U	U	
*	*	

PTA AC: 500, 1k, 2k
 BC: 500, 1k, 2k

Aud Method:

PTA (dB HL) / AI (%)

	AC	BC	AI
Right	26	8	59
Left	25	10	77

Modulok Heavy loss Ad

[Signature]

Nama dokter & tanda tangan
 Doctor's name & signature

SH

FORMULIR PEMERIKSAAN MATA
EYE EXAMINATION FORM

IC MR : 058436
 Name : SAUT HALOM
 Sex : M
 DoB : 1981/07/03
 Ward : Out Patient

CT-80 TOPCON



Mata Kanan (Right Eye)	Parameter	Mata Kiri (Left Eye)
6/6	Visus (Visual acuity)	6/6
-	Koreksi (Correction)	-
20/20	Adisi (Addition)	20/20
	Gerakan Bola Mata (Eye movement)	
	Kesegarian (Allignment)	
	Kelopak Mata (Eyelid)	
	Konjungtiva (Conjunctiva)	
Normal	Kornea (Cornea)	Normal
	Bilik Mata Depan (COA)	
	Pupil	
	Iris	
	Lensa (Lens)	
	Vitreous	
	Fundus	
11	TIO	12
	Lapang Pandang (Visual field)	
	Persepsi Warna (Color perception)	

Kesimpulan ODS Emmetropia

BPN 01/2/2018

Nama dokter & tanda tangan
 Doctor's name & signature

SH	<input type="text"/>	MR : 058436	Name : SAUT HALOMOAN.S SEMBIRING, TN
HASIL PEMERIKSAAN SPIROMETRI SPIROMETRY REPORT		Sex : M	
		DoB : 1981/07/03	
		Ward : Out Patient	

No. Rekam Medik (Medical Record)	Tn Saut
Nama (Name)	
Jenis Kelamin (Sex)	Laki ²
Usia (Age)	36 th
Tinggi Badan (Height)	161
Berat Badan (Weight)	80 kg
Perusahaan (Company)	

ANAMNESIS

Keluhan (Complaint) _____

Kebiasaan Merokok (Smoking) _____

Riwayat Asthma (Asthma) _____

Parameter	Pengukuran (Measurement)	Prediksi (Predicted)	% Prediksi (% Predicted)
VC	2490	4160	60%
FVC	2550	4000	64%
FEV ₁	2530	3390	75%
FEV ₁ / FVC	9920	8070	123%

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

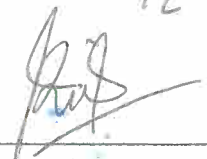
Kesimpulan (Conclusion)

- Restriksi Ringan / Sedang / Berat Restriksi Ringan, tidak ada obstruksi
- Obstruksi Ringan / Sedang / Berat
- Restriksi & Obstruksi Ringan / Sedang / Berat

Rekomendasi (Recommendation)

Pemakaian APD (masker) selama bekerja

..... 8/2 2018



Nama dokter & tanda tangan
Doctor's name & signature

Patient Name : SAUT HALOMOAN.S SEMBIRING, TN
 Address : JL.PRAPATAN DALAM TELAGA SARI
 Age : 36 Thn 7 Bln 6 Hr
 DOB/Sex : 03-07-1981 / Male
 Ward : CHECKUP /
 Physician : dr. Linda Uli Natalisa
 MR. No. : SHBP.00058436
 Clinical Info :

Order Time : 09-02-18 08:59
 Specimen Received : 09-02-18 09:21
 Print Out : 09-02-18 14:11
 Lab No. : 18004237
 Patient Category : ISP, PT
 Reg. No. : CPA1802090007
 Page : 1 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
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HAEMATOLOGY

Hematologi Lengkap

Hemoglobin	15.7	g/dL	14.0 - 18.0	
Jumlah Lekosit	8.26	10 ³ /ul	4.50 - 11.50	
Hitung Jenis				
Eosinofil	2	%	1 - 3	
Basofil	1	%	0 - 2	
Neutrofil Segmen	52	%	50 - 70	
Limfosit	37	%	18 - 42	
Monosit	8	%	2 - 11	
Hematokrit	49.8	%	40.0 - 54.0	
Jumlah Trombosit	231	10 ³ /ul	150 - 450	
Jumlah Eritrosit	5.37	10 ⁶ /uL	4.60 - 6.00	

MCV, MCH, MCHC

MCV	92.7	fL	80.0 - 94.0	
MCH	29.2	pg	26.0 - 32.0	
MCHC	L 31.5	g/L	32.0 - 36.0	
Laju Endap Darah 1 jam	1	mm	0 - 13	

CLINICAL CHEMISTRY

SGOT - SGPT

SGOT	15.1	U/L	<37	
SGPT	16.0	U/L	<45	

Gamma GT	24.0	U/L	8-61	
Trigliserida	H 202	mg/dL	Normal: <150 mg/dL Borderline High: 150-199 mg/dL High: 200-499 mg/dL Very high: >= 500 mg/dL	Enzim
Kolesterol Total	H 208	mg/dL	Desirable: <200 mg/dL Borderline High: 200-239 mg/dL High: >= 240 mg/dL	PAP
HDL Kolesterol	L 35	mg/dL	Major risk: <40 mg/dL Negative risk: >= 60 mg/dL	

Patient Name : SAUT HALOMOAN.S SEMBIRING, TN
 Address : JL.PRAPATAN DALAM TELAGA SARI
 Age : 36 Thn 7 Bln 6 Hr
 DOB/Sex : 03-07-1981 / Male
 Ward : CHECKUP
 Physician : dr. Linda Uli Natalisa
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 Page : 2 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
LDL Kolesterol	148	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	94	mg/dL	76 - 100	
Ureum Darah	18.0	mg/dL	<50	
Kreatinin Darah	0.87	mg/dL	0.70 - 1.20	
Asam Urat	5.0	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	L 1.010		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	0-2	/lpb	1 - 5
Eritrosit	0-2	/lpb	0 - 1
Silinder	Negatif		
Sel Epitel	1-3	/lpk	0 - 2

Patient Name : SAUT HALOMOAN.S SEMBIRING, TN
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 Page : 3 / 3

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

Lekosit	0-1	/lpb	0 - 1
Eritrosit	0-1	/lpb	0 - 1
Parasit	Negatif		Negatif

Clinical Pathologist



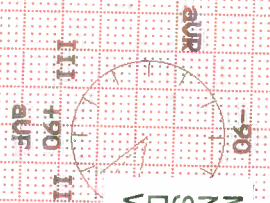
dr. Rita Dewi K, Sp. PK

Authorized By Nur Audia
 Authorisation Date : 09-02-18 14:11

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

Measurement Results:

QRS : 108 ms
 QT/QTcB : 402 / 390 ms
 PR : 146 ms
 P : 108 ms
 RR/PP : 1064 / 1050 ms
 P/QRS/T : 40 / 50 / 10 degrees
 QTd/QTcBd : 40 / 39 ms
 Sokolow : 1.8 mV
 NK : 8

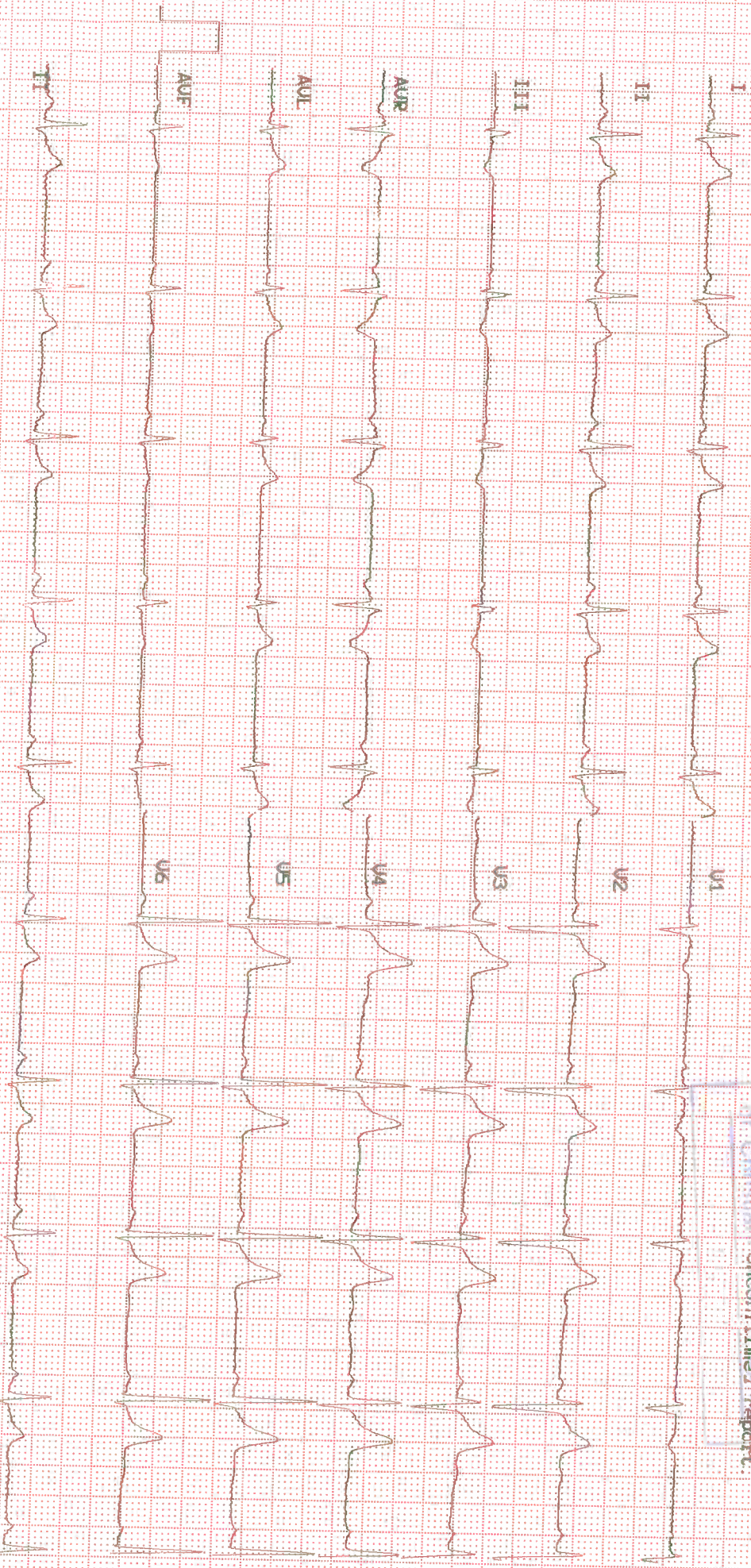


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MR : 058436
 Name : SAUT HALOMOAN S SEMBIRING, TN
 Sex : M
 DOB : 1981/07/03
 Ward : Out Patient

Interpretation:

SRI



**TREADMILL EXERCISE TEST
(PROTOKOL BRUCE)**

Nama : Tn. Saut Tanggal Treadmill : 09 Februari 2018
 Umur : 36 thn Berat : 80 kg
 Jenis Kelamin : Laki - Laki Tinggi : 161 cm
 Perusahaan : PT. Inspektindo Tekanan Darah Awal : 113/66 mmHg

❖ Lama test : 09 Menit 36 Detik
 ❖ Denyut Jantung maksimal : 166 x/menit (90% MHR)
 ❖ Tekanan darah maksimal : 168/74 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 : 12.10 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. Tingkatkan % pola hidup sehat = Kurangi konsumsi alkohol & lemak.
 2. Latihan teratur = 3-5x/m @ 30mp.

Dokter Pemeriksa

dr. Christiani Muljono, Sp. JP
Siloam Hospitals Balikpapan

Patient ID: 0584316
 Date: 2018
 13.52.33
 Male 161 cm 50 kg
 Race: Asian

Test Reason:
 Medical History:

Ref MD: Ordering MD:
 Technician: Firm Test Type:
 Comment:

HR1 C1: 100% of predicted exercise time (9) 76
 Max HR: 166 bpm 90% of max predicted 184 bpm HR at rest: 73
 Minimum workload: 12.10 METS
 Max ST: 1.54 mm 0.00 mV/s in HR EXERCISE STAGE 4 09:37
 Arrhythmia: P:VC:3
 S1/HR index: 1.83 μ V/bpm
 HR reserve used: 78 %
 HR recovery: 22 bpm
 Freq. VF: recovery: 0 VT/min
 ST/HR hysteresis: 0.053 mV (mm)
 QRS duration: BASELINE: 100 ms, PEAK EX: 100 ms, REC: 104 ms
 Location Number: * 0 *

Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	Workload (METS)	HR (bpm)	BP (mmHg)	RPP (mmHg*bp/min)	VE (l/min)	ST Level (mV)	Comment
PRETEST	SUPINE	00:02	0.00	0.00	1.0	72	113/66	8136	0	-	
	STANDING	00:51	0.00	0.00	1.0	72			0	-0.35	
	HYPERV.	00:03	0.00	0.00	1.0	72			0	-0.30	
	WARM-UP	01:54	1.60	0.00	1.7	93	121/65	11253	0	-0.20	
EXERCISE	STAGE 1	03:00	2.70	10.00	4.6	122	152/59	18544	0	0.05	
	STAGE 2	03:00	4.00	12.00	7.0	144			0	-0.45	
	STAGE 3	03:00	5.40	14.00	10.0	155	163/92	25265	0	-0.25	
	STAGE 4	00:37	6.80	16.00	12.1	164			0	-1.55	
RECOVERY		04:05	0.00	0.00	1.0	100	168/74	16800	0	-0.15	

GE CASE V6.73 (0)

Unc. Traced

Attending M.

BASILELINE EXERCISE
93 bpm
121/65 mmHg

MAX ST EXERCISE
164 bpm
163/92 mmHg

PEAK EXERCISE
164 bpm
163/92 mmHg

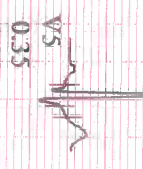
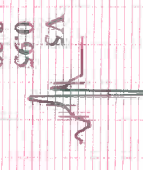
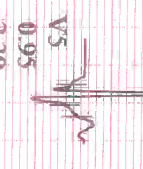
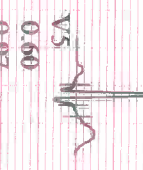
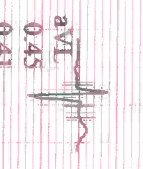
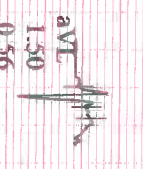
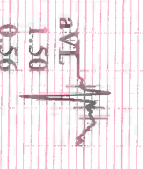
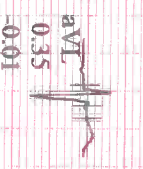
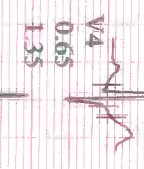
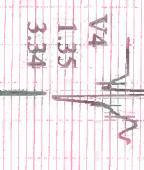
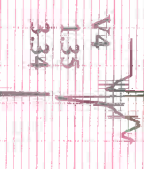
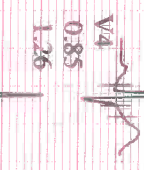
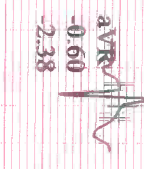
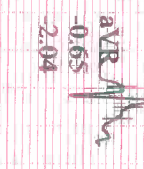
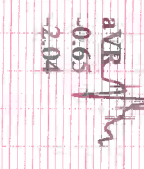
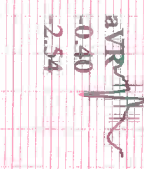
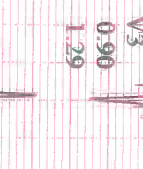
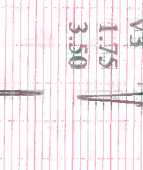
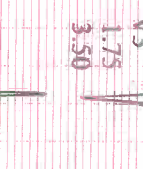
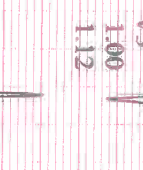
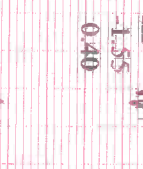
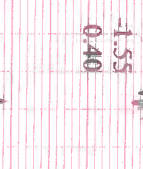
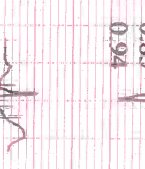
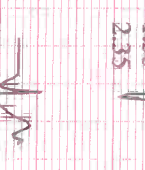
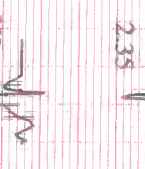
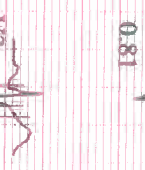
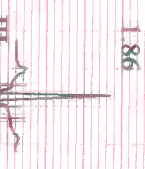
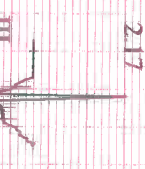
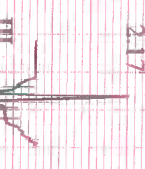
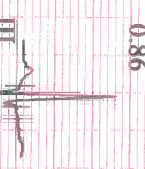
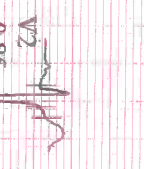
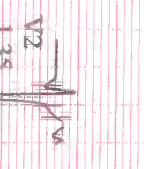
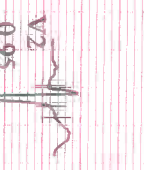
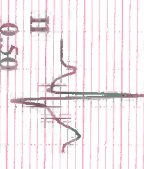
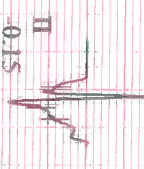
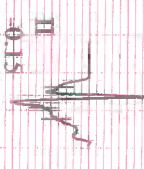
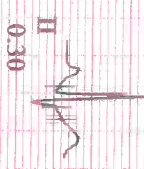
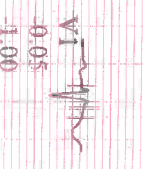
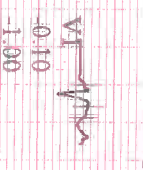
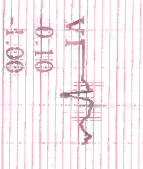
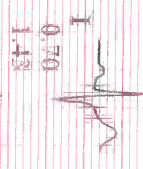
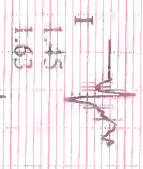
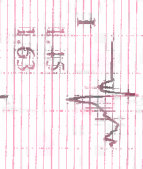
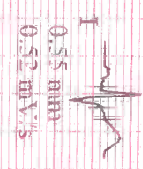
TEST END RECOVERY
103 bpm

BASILELINE EXERCISE
93 bpm
121/65 mmHg

MAX ST EXERCISE
164 bpm
163/92 mmHg

PEAK EXERCISE
164 bpm
163/92 mmHg

TEST END RECOVERY
103 bpm



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

Unc' Signed

Attending M

Patient ID: 058436
 09/02/2018
 13:53:28

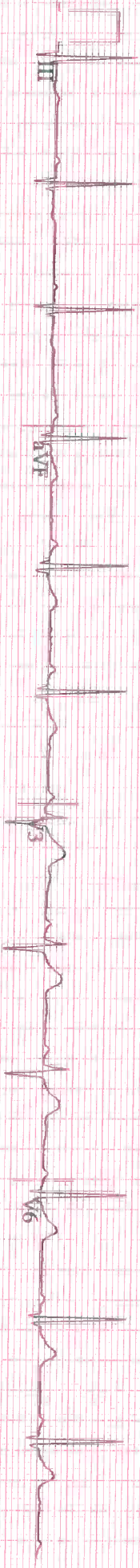
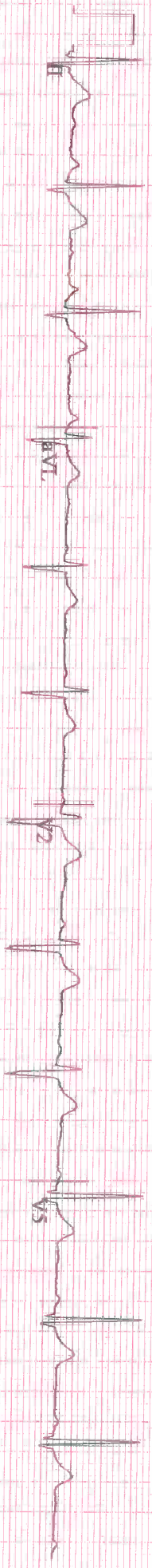
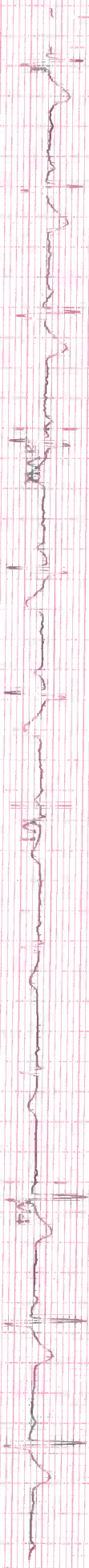
73 bpm
 113.66 mmHg

PRK TEST
 STANDING
 (11:50)

BRUCE
 0.0 km/h
 (11:50)

Measured at 60 bpm
 Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.80	V1	-0.10
II	0.50	V2	1.00
III	-0.35	V3	0.90
aVR	-0.65	V4	0.80
aVL	0.60	V5	0.60
aVF	0.05	V6	0.40



CASE N.673

25 mm/s 10 mm/mV SINEZ, UQUEZ, FRE, ERV3, V6

STARTUP TEST: 13:52:33

Patient ID: 058436
129112 2018
13:55:19

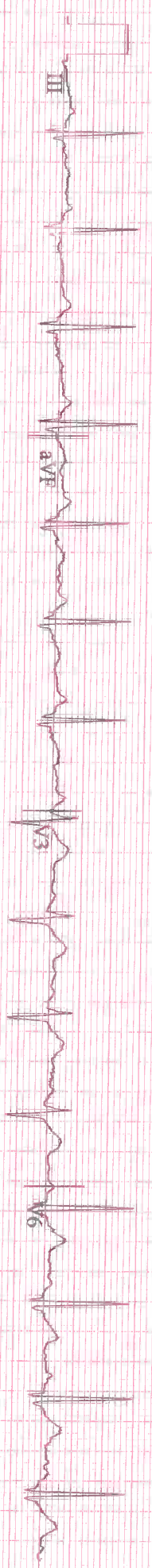
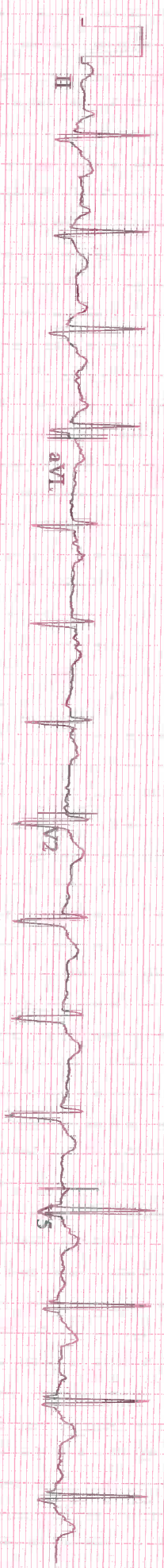
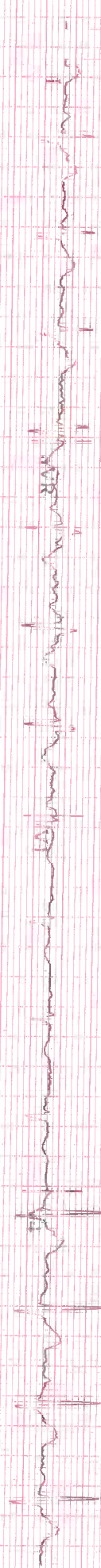
003 Bryant
1711 65 mmHg

PRE-INT
WARREN
107-45

DRUG C1
1-6 km/h
107.0 m/s

Measure at 6h Post J (Ohm mV)
Auto Points

Lead	ST/Tmin	Lead	ST/Tmin
I	0.55	V1	0.90
II	0.40	V2	0.95
III	-0.25	V3	1.00
aVR	-0.50	V4	0.90
aVL	0.45	V5	0.65
aVF	0.10	V6	0.50



Patient ID: 038436
 12-12-2018
 13:58:10

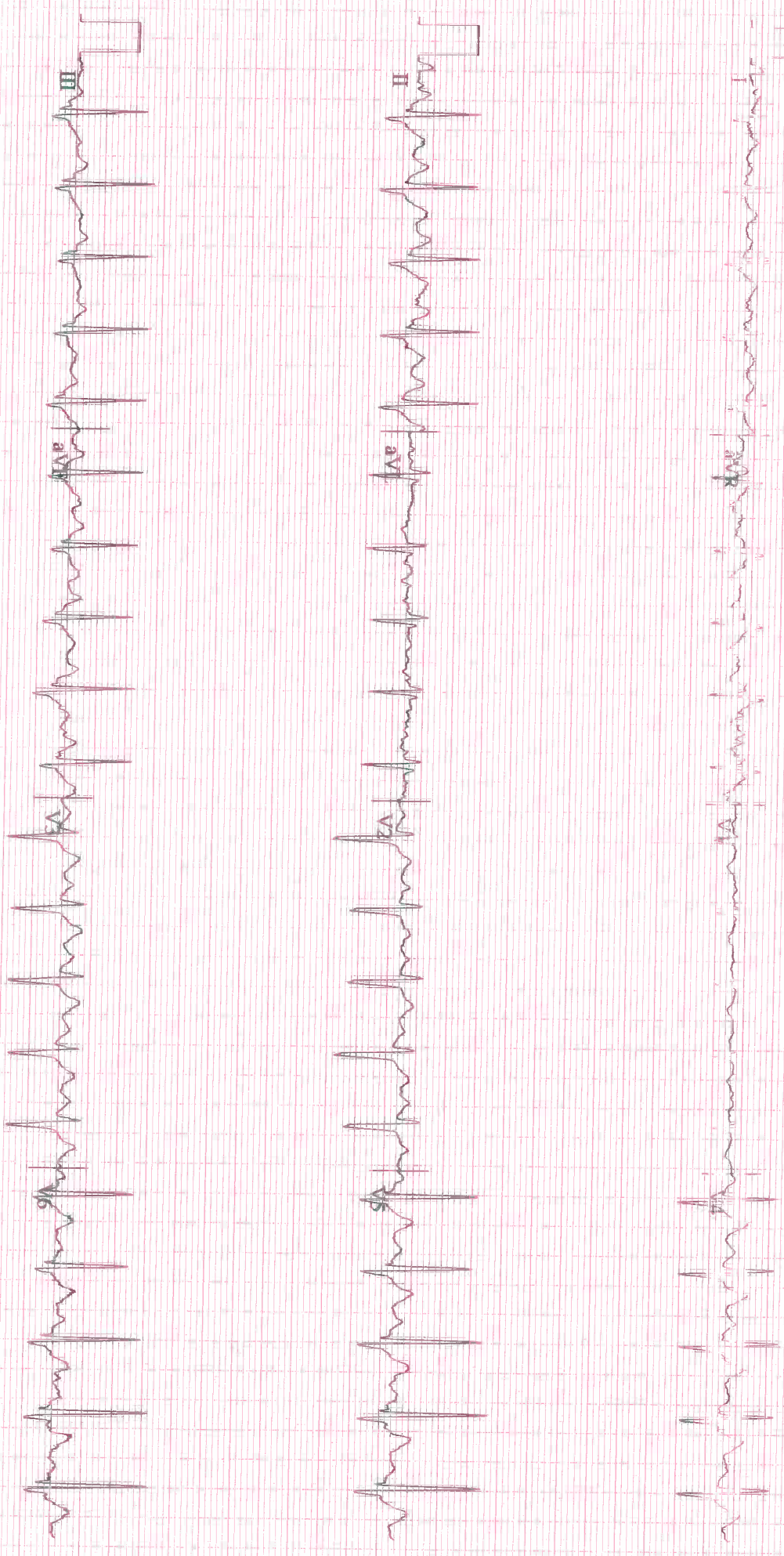
123 bpm
 150 Sv mmHg

EXERCISE
 N/A
 123 bpm

HR: 123
 123 bpm

Measured at Echms Post-Exercise
 Auto Points

Lead	ST (mm)	Lead	ST (mm)
I	0.55	V1	0.65
II	0.70	V2	0.75
III	0.00	V3	1.05
aVR	-0.70	V4	1.05
aVL	0.35	V5	0.90
aVF	0.35	V6	0.60



GE
 CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01Hz FREQ = HR(V5, V6)

Start of Test: 13:52:33

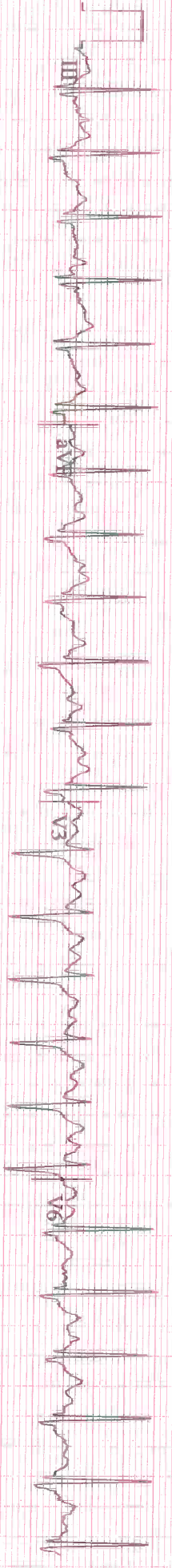
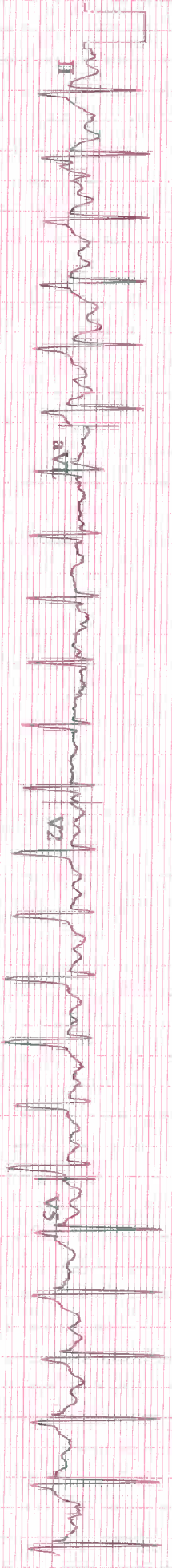
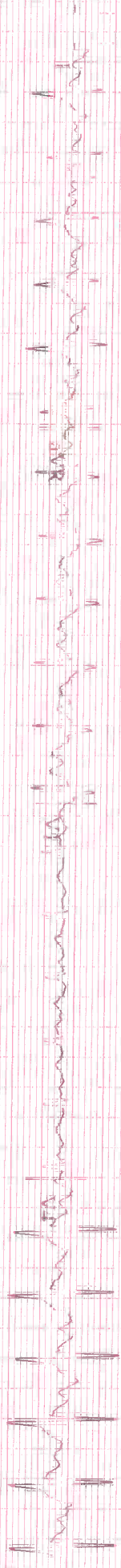
Patient ID: 058436
 19942341X
 14/11/1999

11.2 bpm

11.21 R (SI)
 S1 Acd 2
 11.8-80
 BRIT
 471kntch
 11.2 min

Sirajit Hospital, Dhaka
 Measured at 60mm Post J (I, II, III, aVR, V4)

Lead	ST (mm)	Lead	ST (mm)
I	1.85	V1	-0.20
II	0.35	V2	0.80
III	-0.50	V3	1.00
aVR	-0.60	V4	0.75
aVL	0.70	V5	0.55
aVF	-0.10	V6	0.25



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

Start of Test: 13:52:33

Patient ID: 058436
 09/12/2018
 12:11:00

15 bpm

63/92

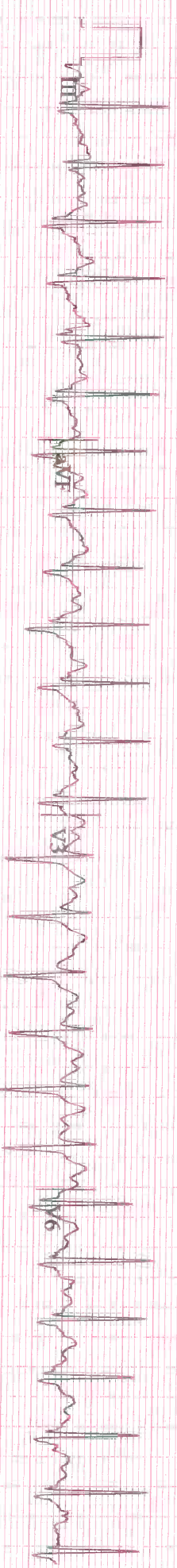
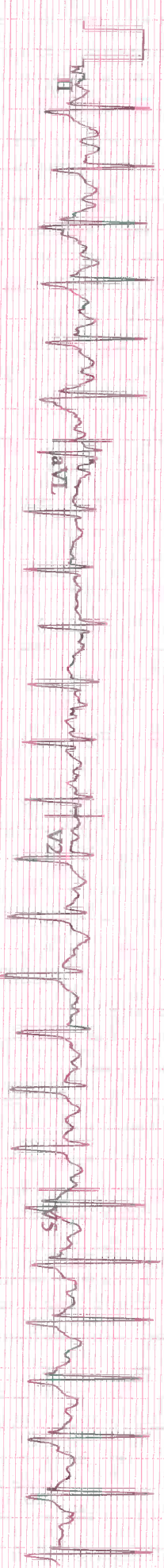
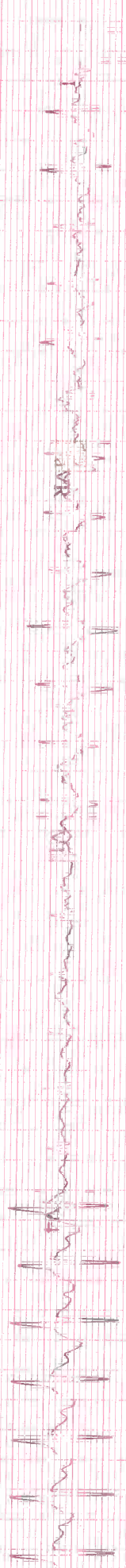
EXECSH
 Signal 3
 (SR-51)

BRIT
 5.3 km/h
 1.4 km/h

1.000
 Measured at 600ms
 Auto Events

m

Lead	ST (mm)	Lead	ST (mm)
I	1.10	V1	0.30
II	1.00	V2	0.80
III	-0.05	V3	2.00
aVR	-1.00	V4	1.65
aVL	0.55	V5	1.10
aVF	0.45	V6	0.80



GE
 CASE V673
 25 mm/s 10 mm/mV 50Hz 0.01Hz FRF HR(V5,V6)

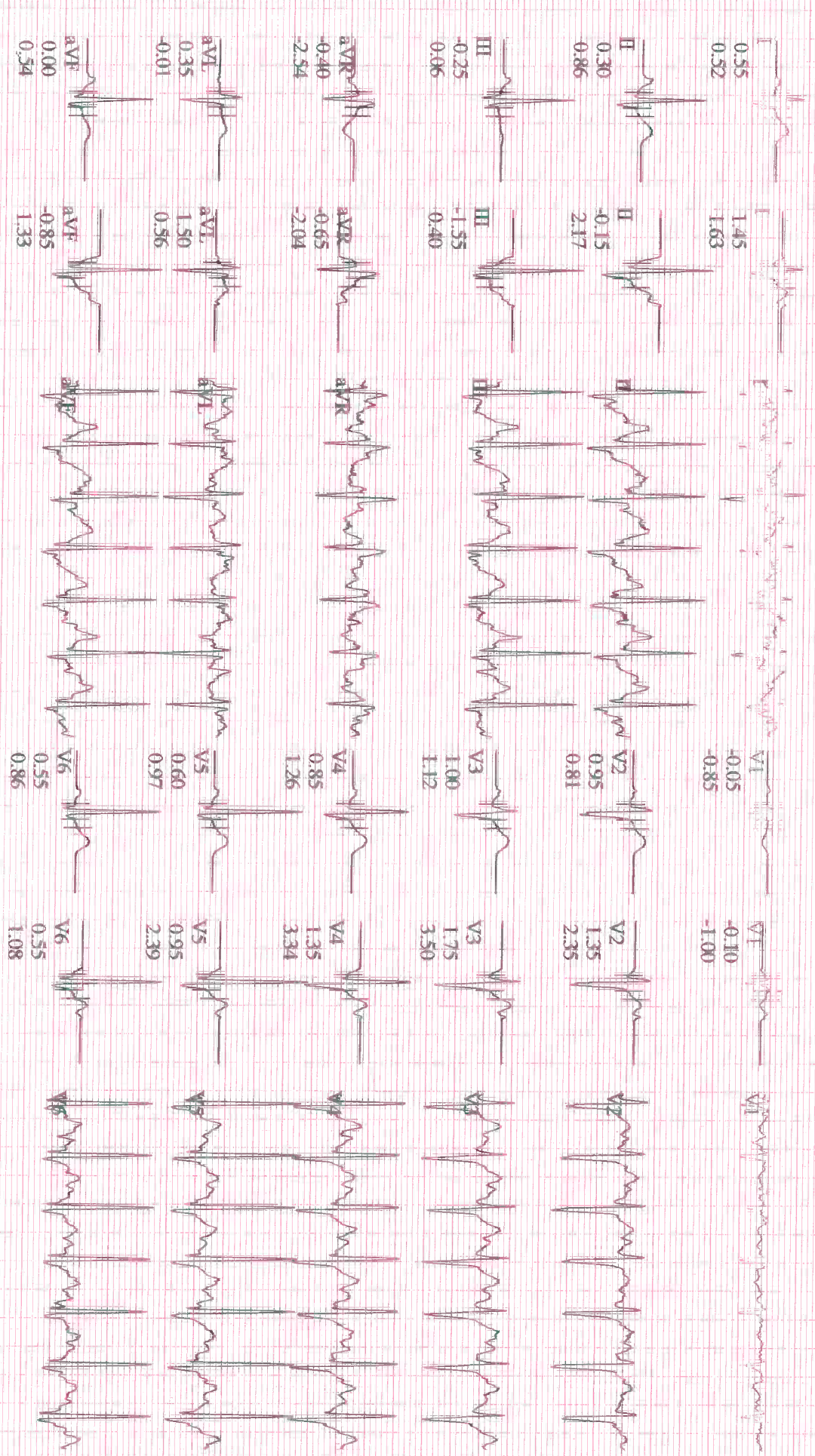
Start of Test: 13:52:33

BASLINE

60 ms post J

CURRENT

ST @ 10mm/mV
60 ms post J



GE

CASE V673

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

Start of Test: 13:52:33

Patient ID: 05846
19#2, 3018
110545

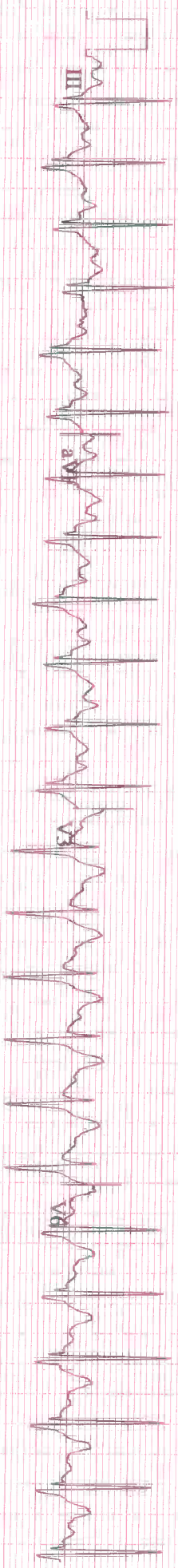
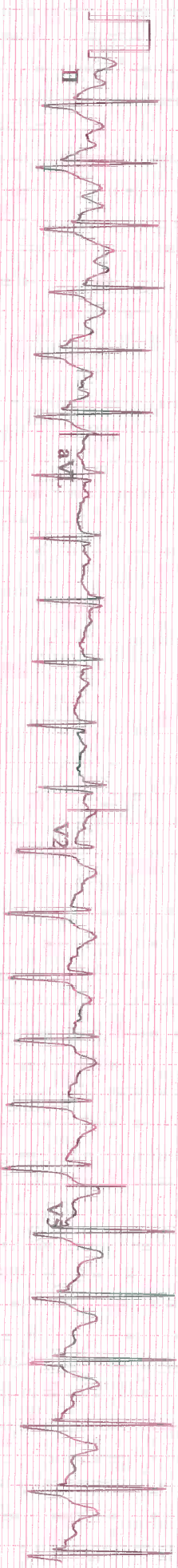
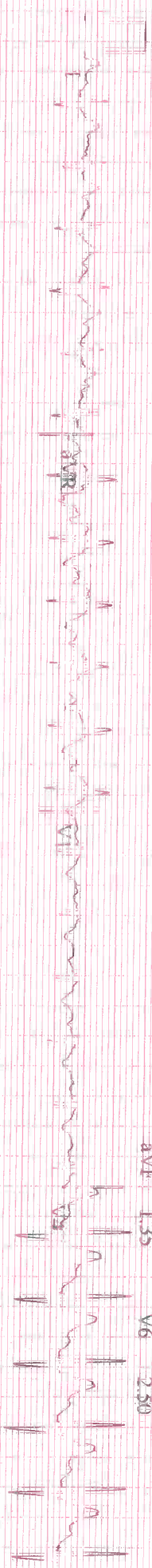
Heartbeat
16382 mmHg

Rate (b/min)
105.50

PR
243ms

QTc
380ms

Lead	ST	ST
ST	ST	ST
II	2.25	2.30
III	1.55	3.50
aVR	-2.05	3.75
aVL	0.65	3.10
aVF	1.35	2.50



GE
CASE V6.73

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

Start of Test: 13:52:33

12-10-2018

RHEIMERY

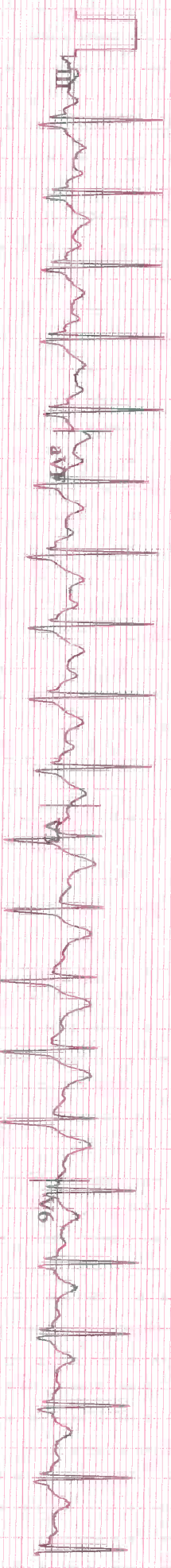
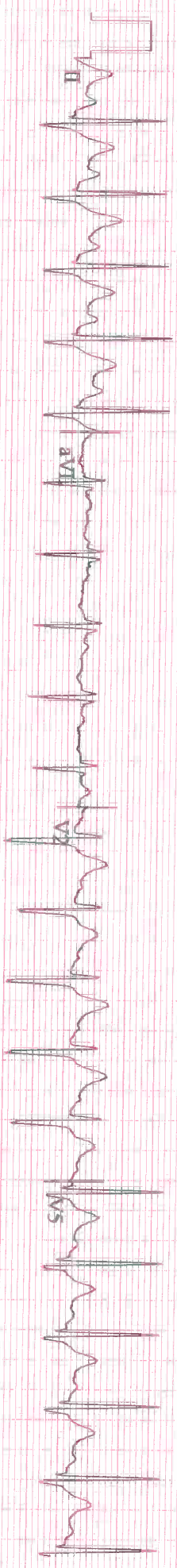
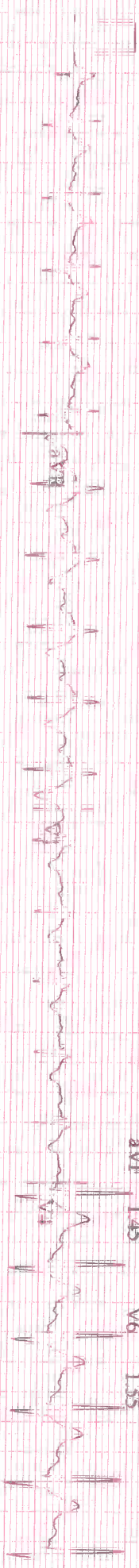
10/10/18

St. Vincent Hospital, East Rutherford

Measured at 67mins Post Admission (mV)

Auto Points

Lead	ST (mV)	Lead	ST (mV)
I	0.65	V1	-0.75
II	2.25	V2	2.15
III	0.55	V3	3.15
aVR	-1.95	V4	2.75
aVL	0.55	V5	2.00
aVF	1.45	V6	1.55



GE

CASE V6.73

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

Start of Test: 13:52:33

Patient: 13:058436
 1949-05-14
 14-07-15

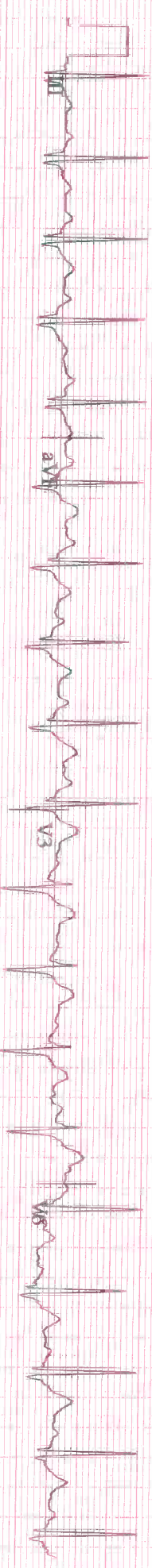
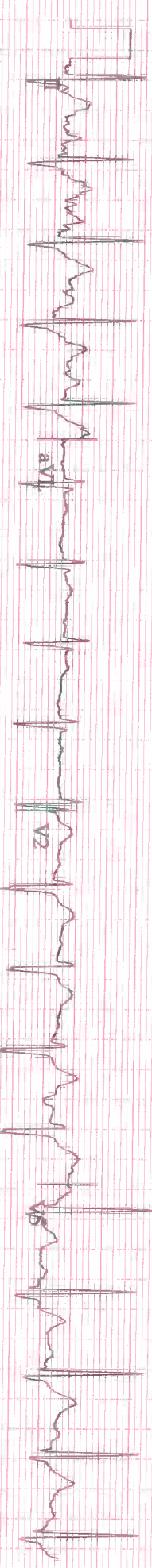
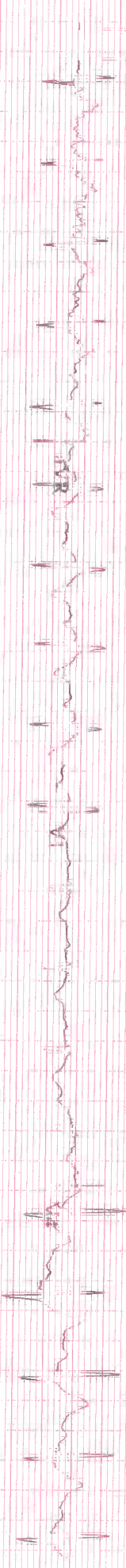
11th Floor
 1487 14 months

RUCONRY
 12-50

1487 14 months
 1487 14 months

National Hospital, Princes Street
 Measured at Right's Post-Tetanic V1
 Value Points

Lead	STIMULY	Lead	STIMULY
I	1.05	V1	0.30
II	1.35	V2	1.00
III	-0.30	V3	1.50
aVR	-1.20	V4	1.35
aVL	0.40	V5	1.00
aVF	0.85	V6	0.75



GE
 CASE V6.73
 25 mm/s 10 mm/mV 50Hz 6.01Hz FRR - HR(V5, V6)

Start of Test: 13:52:33

Patient ID: 0058436
 07/02/2018
 11:20:45

11/20/2011

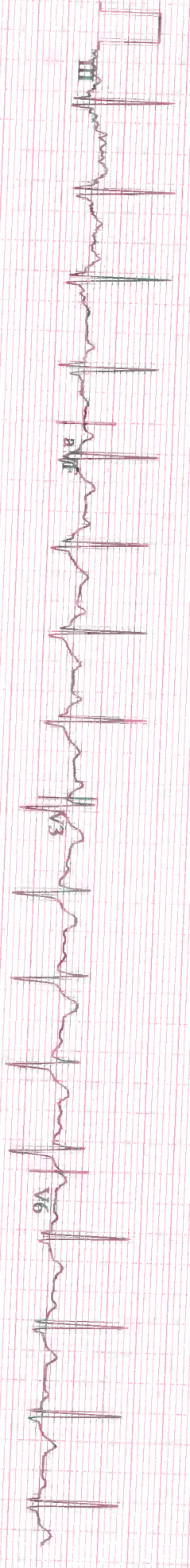
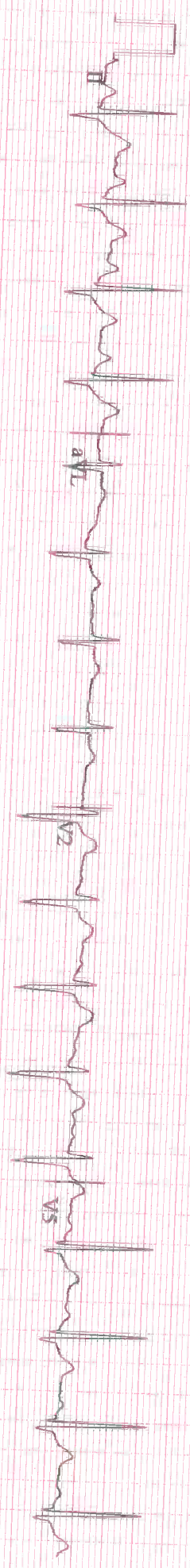
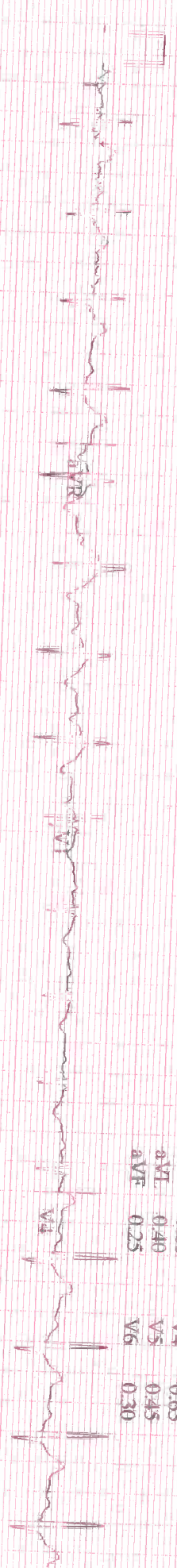
RFV ENERGY

1317 F

Site: 0058436
 Measured at 60mm Post
 Auto Points

2/10
 11/20/2011

Lead	ST (mm)	Lead	ST (mm)
I	0.70	V1	0.05
II	0.65	V2	0.90
III	-0.10	V3	0.95
aVR	-0.65	V4	0.65
aVL	0.40	V5	0.45
aVF	0.25	V6	0.30



GE
 CASE V6.73

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

Startup Test: 12-20-03

Patient Name	: SAUT HALOMOAN.S SEMBIRING, TN	Patient ID BALIKPAPAN	: SHBP.00058436
Sex / Age	: M / 036Yrs	Accession No.	: 10000004615831
Modality	: US	Scan Date	: 09-02-2018
Procedure	: UPPER ABDOMEN USG	Report Date/Time	: 09-02-2018 10:57:45
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, 36 Thn pro MCU pada 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.

Patient Name	: SAUT HALOMOAN.S SEMBIRING, TN	Patient ID	: SHBP.00058436
Sex / Age	: M / 036Yrs	Accession No.	: 10000004615831
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US- Upper Abdomen, Male

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 • KANAN: Normal
 • KIRI: Normal

Impression:

Pria, 36 Thn pro MCU pada USG Upper Abdomen :
 Tidak diketemukan adanya kelainan yg significans



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