



## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Surname <b>SHARMA</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                           |
| Forenames <b>SACHIN</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                           |
| Address                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                           |
| Home telephone number                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                           |
| Place of examination <b>NMC AL-HQA</b>                                                                                                                                                                                                                                                                                                                                                                                                            | Date <b>12/01/2022</b>                                                                                                    |
| If a dependant enter employee's name here:                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                           |
| Surname:                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                           |
| Forenames:                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                           |
| Birth date: <b>17/10/1957</b>                                                                                                                                                                                                                                                                                                                                                                                                                     | Nationality: <b>INDIAN</b>                                                                                                |
| Country of birth:                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                           |
| Religion:                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                           |
| <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated / Divorced |
| Relationship to employee<br><input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter                                                                                                                                                                                                                                                                                                                          |                                                                                                                           |
| Number of children:                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                           |
| Reason for examination                                                                                                                                                                                                                                                                                                                                                                                                                            | Pre-Employment <input checked="" type="checkbox"/> Job:<br>Pre-Overseas <input type="checkbox"/> Area:                    |
| Name and address of family doctor                                                                                                                                                                                                                                                                                                                                                                                                                 | List your last 3 jobs                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (1)                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (2)                                                                                                                       |
| Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                          | Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>                                                   |
| DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                           |
| Y                                                                                                                                                                                                                                                                                                                                                                                                                                                 | N                                                                                                                         |
| 1. Sinus trouble                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input checked="" type="checkbox"/>                                                                                       |
| 2. Neck swelling/glands                                                                                                                                                                                                                                                                                                                                                                                                                           | <input checked="" type="checkbox"/>                                                                                       |
| 3. Difficulty in vision                                                                                                                                                                                                                                                                                                                                                                                                                           | <input checked="" type="checkbox"/>                                                                                       |
| 4. Any ear discharge                                                                                                                                                                                                                                                                                                                                                                                                                              | <input checked="" type="checkbox"/>                                                                                       |
| 5. Asthma/bronchitis                                                                                                                                                                                                                                                                                                                                                                                                                              | <input checked="" type="checkbox"/>                                                                                       |
| 6. Hayfever /other significant allergy                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 7. Any skin trouble                                                                                                                                                                                                                                                                                                                                                                                                                               | <input checked="" type="checkbox"/>                                                                                       |
| 8. Tuberculosis                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input checked="" type="checkbox"/>                                                                                       |
| 9. Shortness of breath                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 10. Coughed/vomited blood                                                                                                                                                                                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/>                                                                                       |
| 11. Severe abdominal pain                                                                                                                                                                                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/>                                                                                       |
| 12. Stomach ulcer                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input checked="" type="checkbox"/>                                                                                       |
| 13. Recurrent indigestion                                                                                                                                                                                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/>                                                                                       |
| 14. Jaundice or hepatitis                                                                                                                                                                                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/>                                                                                       |
| 15. Gall Bladder disease                                                                                                                                                                                                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/>                                                                                       |
| 16. Marked change in bowel habits                                                                                                                                                                                                                                                                                                                                                                                                                 | <input checked="" type="checkbox"/>                                                                                       |
| 17. Blood in stools (motions)                                                                                                                                                                                                                                                                                                                                                                                                                     | <input checked="" type="checkbox"/>                                                                                       |
| 18. Marked change in weight                                                                                                                                                                                                                                                                                                                                                                                                                       | <input checked="" type="checkbox"/>                                                                                       |
| 19. Varicose veins                                                                                                                                                                                                                                                                                                                                                                                                                                | <input checked="" type="checkbox"/>                                                                                       |
| 20. Lump in breast/arm/leg                                                                                                                                                                                                                                                                                                                                                                                                                        | <input checked="" type="checkbox"/>                                                                                       |
| 21. Cancer                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input checked="" type="checkbox"/>                                                                                       |
| 22. Heart Disease                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input checked="" type="checkbox"/>                                                                                       |
| 23. Rheumatic fever                                                                                                                                                                                                                                                                                                                                                                                                                               | <input checked="" type="checkbox"/>                                                                                       |
| 24. Abnormal heartbeat                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 25. High blood pressure                                                                                                                                                                                                                                                                                                                                                                                                                           | <input checked="" type="checkbox"/>                                                                                       |
| 26. Stroke                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input checked="" type="checkbox"/>                                                                                       |
| 27. Serious chest pain                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 28. Any blood disease                                                                                                                                                                                                                                                                                                                                                                                                                             | <input checked="" type="checkbox"/>                                                                                       |
| 29. Kidney disease                                                                                                                                                                                                                                                                                                                                                                                                                                | <input checked="" type="checkbox"/>                                                                                       |
| 30. Blood in urine                                                                                                                                                                                                                                                                                                                                                                                                                                | <input checked="" type="checkbox"/>                                                                                       |
| 31. Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input checked="" type="checkbox"/>                                                                                       |
| 32. Headaches/migraine                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 33. Dizziness/fainting                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 34. Epilepsy                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input checked="" type="checkbox"/>                                                                                       |
| 35. Joints/spinal trouble                                                                                                                                                                                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/>                                                                                       |
| 36. Surgical operation                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/>                                                                                       |
| 37. Serious accident/fracture                                                                                                                                                                                                                                                                                                                                                                                                                     | <input checked="" type="checkbox"/>                                                                                       |
| 38. Tropical disease                                                                                                                                                                                                                                                                                                                                                                                                                              | <input checked="" type="checkbox"/>                                                                                       |
| 39. Fear of heights                                                                                                                                                                                                                                                                                                                                                                                                                               | <input checked="" type="checkbox"/>                                                                                       |
| HAVE YOU EVER BEEN:-                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                           |
| 40. Rejected for employment or insurance for medical reasons                                                                                                                                                                                                                                                                                                                                                                                      | <input checked="" type="checkbox"/>                                                                                       |
| 41. Awarded benefits for industrial injury/illness                                                                                                                                                                                                                                                                                                                                                                                                | <input checked="" type="checkbox"/>                                                                                       |
| 42. Treated for a mental condition, e.g. depression                                                                                                                                                                                                                                                                                                                                                                                               | <input checked="" type="checkbox"/>                                                                                       |
| 43. Treated for problem drinking or drug abuse                                                                                                                                                                                                                                                                                                                                                                                                    | <input checked="" type="checkbox"/>                                                                                       |
| 44. Exposed to toxic substance or noise                                                                                                                                                                                                                                                                                                                                                                                                           | <input checked="" type="checkbox"/>                                                                                       |
| FOR WOMEN ONLY                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                           |
| Have you ever had:-                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                           |
| 45. An abnormal smear                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>                                                                                                  |
| 46. Any gynaecological treatment                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>                                                                                                  |
| 47. Are you pregnant?                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>                                                                                                  |
| 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>                                                                                                  |
| How much tobacco each day?                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                           |
| Average daily alcohol consumption                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                           |
| Have you ever taken illicit drugs? ( ) PDO test all new/potential employees for illicit/recreational drugs                                                                                                                                                                                                                                                                                                                                        |                                                                                                                           |
| FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( )<br>Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )                                                                                                                                                                                                                                                                             |                                                                                                                           |
| PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                           |
| I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information. |                                                                                                                           |
| Date:                                                                                                                                                                                                                                                                                                                                                                                                                                             | Signature of Applicant: <i>Sachin Sharma</i>                                                                              |

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE  
 Further details of medical history and recreational activities

|                                           |   |                          |  |
|-------------------------------------------|---|--------------------------|--|
| N = Normal A = Abnormal (please describe) |   | PHYSICAL EXAMINATION     |  |
| N                                         | A |                          |  |
| <input checked="" type="checkbox"/>       |   | 1. Eyes & Pupils         |  |
| <input checked="" type="checkbox"/>       |   | 2. E.N.T.                |  |
| <input checked="" type="checkbox"/>       |   | 3. Teeth & Mouth         |  |
| <input checked="" type="checkbox"/>       |   | 4. Lungs & Chest         |  |
| <input checked="" type="checkbox"/>       |   | 5. Cardiovascular System |  |
| <input checked="" type="checkbox"/>       |   | 6. Abdo. Viscera         |  |
| <input checked="" type="checkbox"/>       |   | 7. Hemial Orifices       |  |
| <input checked="" type="checkbox"/>       |   | 8. Anus & Rectum         |  |
| <input checked="" type="checkbox"/>       |   | 9. Genito-urinary        |  |
| <input checked="" type="checkbox"/>       |   | 10. Extremities          |  |
| <input checked="" type="checkbox"/>       |   | 11. Musculo-skeletal     |  |
| <input checked="" type="checkbox"/>       |   | 12. Skin & Varicose Vns. |  |
| <input checked="" type="checkbox"/>       |   | 13. C.N.S.               |  |

|              |              |      |        |         |                |                                                            |                  |                |
|--------------|--------------|------|--------|---------|----------------|------------------------------------------------------------|------------------|----------------|
| HEIGHT<br>cm | WEIGHT<br>kg | BMI  | B.P.   | PULSE   | HEARING<br>L R | VISION<br>DISTANT NEAR<br>R L R L<br>Uncorrected Corrected | Colour<br>Vision | Blood<br>Group |
| 170          | 60           | 20.7 | 118/78 | 65/min. | L (N)<br>R (N) | Uncorrected: R 6, L 6<br>Corrected: R 6, L 6               | (N)              |                |

|                                     |   |                                             |                                     |   |
|-------------------------------------|---|---------------------------------------------|-------------------------------------|---|
| N                                   | A | LABORATORY AND OTHER SPECIAL INVESTIGATIONS | N                                   | A |
| <input checked="" type="checkbox"/> |   | 1. Urinalysis                               | <input checked="" type="checkbox"/> |   |
| <input checked="" type="checkbox"/> |   | 2. Hb, Bloodcount, ESR                      | <input checked="" type="checkbox"/> |   |
| <input checked="" type="checkbox"/> |   | 3. LFT, RFT, RBS                            | <input checked="" type="checkbox"/> |   |
| <input checked="" type="checkbox"/> |   | 4. Drug Screen                              | <input checked="" type="checkbox"/> |   |
| <input checked="" type="checkbox"/> |   | 5. Lipids (40 years +)                      | <input checked="" type="checkbox"/> |   |
| <input checked="" type="checkbox"/> |   | 6. Sickie Cell test                         | <input checked="" type="checkbox"/> |   |
|                                     |   | 7. Audiogram                                |                                     |   |
|                                     |   | 8. Lung Function                            |                                     |   |
|                                     |   | 9. Chest X-Ray                              |                                     |   |
|                                     |   | 10. ECG                                     |                                     |   |
|                                     |   | 11. CVS risk for 40 yrs. & above            |                                     |   |
|                                     |   | 12. HIV, Hepatitis screening                |                                     |   |

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

ASSESSMENT:

☒ FIT ALL AREAS
 ☐ FIT WITH RESTRICTION
 ☐ TEMPORARY UNFIT
 ☐ UNFIT

Date: 14/09/2021 Name (Block Capitals): Dr. / Nurse DO. SHIVAKUMAR Signature: [Signature]

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse Signature:

# DEPARTMENT OF LABORATORY MEDICINE

|                                                              |                                                      |
|--------------------------------------------------------------|------------------------------------------------------|
| <b>File No:</b> 50083797                                     | <b>Report No:</b> 0062416                            |
| <b>Name:</b> SACHIN SHARMA                                   | <b>Sample Date:</b> 12/09/2022 <b>Time:</b> 10:22    |
| <b>Address:</b>                                              | <b>Received By:</b>                                  |
| <b>Gender:</b> M <b>Age:</b> 34 Y <b>Nationality:</b> INDIAN | <b>Received Date:</b> <b>Time:</b> 12:15             |
| <b>GSM No.:</b> 98379715 <b>ID Card No.:</b> V6038032        | <b>Report Date:</b> 12/09/2022 <b>Time:</b> 12:15    |
| <b>Ref. By:</b> DR ALI AL TAHIR ALI MUSA                     | <b>Bill No:</b> 0181332 <b>Bill Date:</b> 12/09/2022 |
|                                                              | <b>Report Status:</b> Final                          |

| INVESTIGATION                  | RESULT                      | REFERENCE RANGE                                                                                                                                       |
|--------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| PDO PACKAGE BELOW 40 YEARS     |                             |                                                                                                                                                       |
| RANDOM BLOOD SUGAR             | 4.59 mmol/L                 | 4.11 -7.9mmol/L                                                                                                                                       |
| CREATININE                     | 80.60 µ mol/L               | Adults:<br>MALE: 62 – 106 µ mol/L<br>FEMALE: 44 - 80 µ mol/L                                                                                          |
| SGPT (ALT)                     | 15.35 U/L                   | MALE : up to 41 U/L,<br>FEMALE : up to 33 U/L.                                                                                                        |
| TOTAL WBC COUNT                | 4.40 x 10 <sup>3</sup> / µL | 4.00-11.00 x 10 <sup>3</sup> / µL                                                                                                                     |
| DIFFERENTIAL COUNT             |                             |                                                                                                                                                       |
| NEUTROPHIL (%)                 | 53.30 %                     | 40-75%                                                                                                                                                |
| LYMPHOCYTE (%)                 | 32.20 %                     | 20-45%                                                                                                                                                |
| MONOCYTE (%)                   | 12.40 %                     | 2-8%                                                                                                                                                  |
| EOSINOPHIL (%)                 | 1.90 %                      | 1-6%                                                                                                                                                  |
| BASOPHIL (%)                   | 0.20 %                      | 0-1%                                                                                                                                                  |
| ERYTHROCYTE SEDIMENTATION RATE | 05 mm/1st hr                | MALE:0-15 mm/ 1st hr<br>FEMALE:0-20 mm/ 1st hr                                                                                                        |
| HAEMOGLOBIN                    | 13.70 gm/dl                 | Male : 13 -18 gm/dl<br>Female:11-15 gm /dl<br>childrens upto 1year-11.0 - 13.0 gm /dl<br>upto12years-11.5 - 14.5 gm /dl<br>cord blood:13 -19.5 gm /dl |
| SICKLE CELL                    | NEGATIVE                    |                                                                                                                                                       |
| Method : Solubility test       |                             |                                                                                                                                                       |
| <b>URINE ROUTINE</b>           |                             |                                                                                                                                                       |
| URINE BIOCHEMISTRY             |                             |                                                                                                                                                       |
| URINE GLUCOSE                  | NEGATIVE                    | NEGATIVE                                                                                                                                              |
| URINE PROTEIN                  | NEGATIVE                    | NEGATIVE                                                                                                                                              |
| URINE KETONE                   | NEGATIVE                    | NEGATIVE                                                                                                                                              |

Verified By:



10593

Lab Technologist

MOH License No:

Electronically signed at: 9/12/2022 12:15:00

Approved By:



DR ROSE MARY

Specialist Pathologist

MOH License No: 18178

Electronically signed at: 12/09/2022 12:19:00

Printed at: 12/09/2022 7:46:18 PM

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www.nmc-hospital.com

DEPARTMENT OF LABORATORY MEDICINE

|                                                              |                                                      |
|--------------------------------------------------------------|------------------------------------------------------|
| <b>File No:</b> 50083797                                     | <b>Report No:</b> 0062416                            |
| <b>Name:</b> SACHIN SHARMA                                   | <b>Sample Date:</b> 12/09/2022 <b>Time:</b> 10:22    |
| <b>Address:</b>                                              | <b>Received By:</b>                                  |
| <b>Gender:</b> M <b>Age:</b> 34 Y <b>Nationality:</b> INDIAN | <b>Received Date:</b> <b>Time:</b>                   |
| <b>GSM No.:</b> 98379715 <b>ID Card No.:</b> V6038032        | <b>Report Date:</b> 12/09/2022 <b>Time:</b> 12:15    |
| <b>Ref. By:</b> DR ALI AL TAHIR ALI MUSA                     | <b>Bill No:</b> 0181332 <b>Bill Date:</b> 12/09/2022 |
|                                                              | <b>Report Status:</b> Final                          |

| INVESTIGATION    | RESULT                               | REFERENCE RANGE |
|------------------|--------------------------------------|-----------------|
| URINE BILIRUBIN  | NEGATIVE                             | NEGATIVE        |
| NITRITE          | NEGATIVE                             | NEGATIVE        |
| URINE PH         | 6.0                                  | 4.6-8.0         |
| SPECIFIC GRAVITY | 1.025                                | 1.010-1.030     |
| BLOOD            | NEGATIVE                             | NEGATIVE        |
| UROBILINOGEN     | NORMAL                               | NORMAL          |
| URINE MACROSCOPY |                                      |                 |
| COLOUR           | YELLOW                               |                 |
| APPEARANCE       | TURBID                               |                 |
| URINE MICROSCOPY |                                      |                 |
| RBC              | 1-3 /hpf                             | 0-3             |
| PUSCELLS         | 4-6 /hpf                             | 0-5             |
| EPITHELIAL CELLS | 10-12 /hpf                           | NIL             |
| CRYSTAL          | AMORPHOUS URATES<br>PRESENT(++) /hpf | NIL             |
| CAST             | NIL /hpf                             | NIL             |
| BACTERIA         | NIL                                  | NIL             |
| MUCOUS THREAD    | NIL                                  | NIL             |

Verified By:



10593

Lab Technologist

MOH License No:  
Electronically signed at: 9/12/2022 12:15:00

Approved By:



DR ROSE MARY

Specialist Pathologist

MOH License No: 18178  
Electronically signed at: 12/09/2022 12:19:00

Printed at: 12/09/2022 7:46:18 PM

Page : 2 of 2

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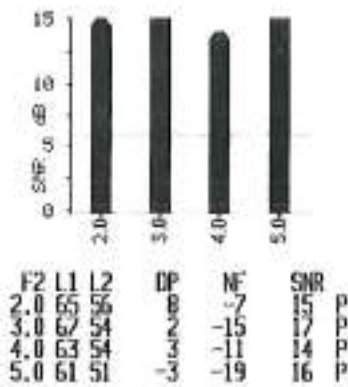
# AUDIOMETRY REPORT

Name of the Patient SACHIN SHARMA  
 Age 34Y Sex male MRN 50083797 Date of Test 12/09/22

U107.05  
 11-SEP-22 23:16  
 DP 2s 2 sec avg  
 SN: G11005649 G12009368

NAME:

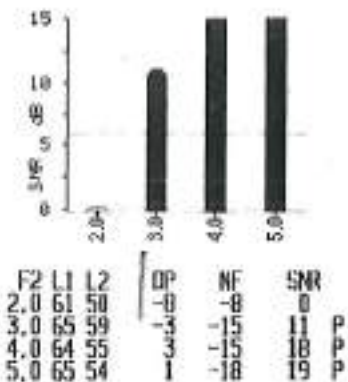
Left: Pass



U107.05  
 11-SEP-22 23:16  
 DP 2s 2 sec avg  
 SN: G11005649 G12009368

NAME:

Right: Pass



*Signature of the Technician*  
 Signature of the Technician

NMCOMAN/DOC/NSG/75



## Pulmonary Function Report

## Subject Information

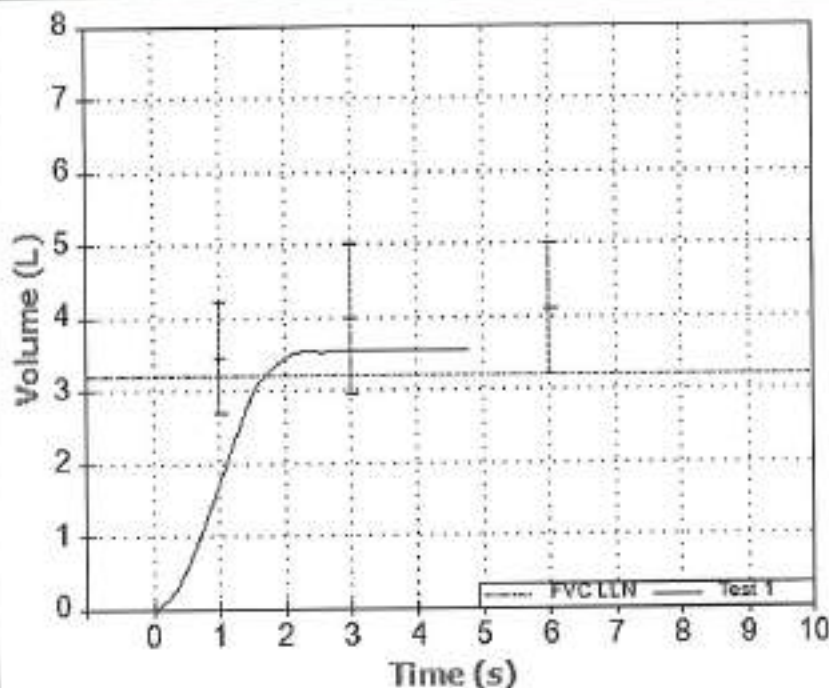
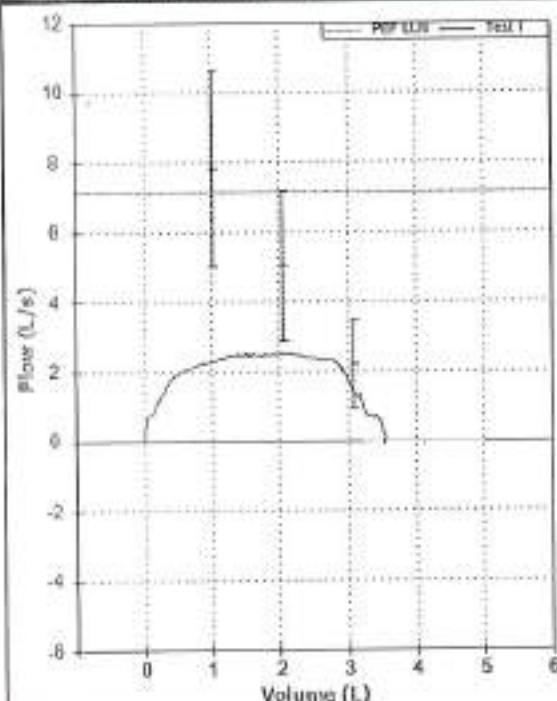
|             |                   |               |          |                |            |
|-------------|-------------------|---------------|----------|----------------|------------|
| ID:         | 2022255_105313181 | Alternate ID: | 50083797 | Middle Name:   |            |
| Last Name:  | Sharma            | First Name:   | Sachin   | Date of Birth: | 17/10/1987 |
| Population: | Asian             | Gender:       | Male     | Weight:        | 60.0 kg    |
| Age:        | 34                | Height:       | 170 cm   |                |            |
| BMI:        | 20.8              | Smoking:      | Smoker   |                |            |

## Test Session Information

|               |                  |               |                  |                |         |
|---------------|------------------|---------------|------------------|----------------|---------|
| Test Date:    | 12/09/2022 10:58 | Device:       | ALPHA Touch      | Serial Number: | 32166   |
| No. of Tests: | 2                | Accuracy Chk: | 30/05/2019 15:42 | User:          | user    |
| Pred. Values: | ERS 93           | Pred. Factor: | 90%              | Posture:       | Sitting |

Flow/Volume Graph

Volume/Time Graph



## Results

| Parameter      | Pred | LLN  | Best  | % Pred. | Z-Score |
|----------------|------|------|-------|---------|---------|
| FVC (L)        | 4.11 | 3.21 | 3.54  | 86      | -1.04   |
| FEV1 (L)       | 3.45 | 2.69 | 2.51* | 73      | -2.03   |
| FEV1 Ratio     | 0.81 | 0.69 | 0.71  | 88      | -1.37   |
| FEV6 (L)       | 4.11 | 3.21 | 3.54  | 86      | -1.04   |
| PEF (L/min)    | 548  | 429  | 152*  | 28      | -5.45   |
| FEF25-75 (L/s) | 4.54 | 2.83 | 2.43* | 54      | -2.02   |

Values at BTPS, \*Below lower limit of normality (LLN)

## Session Quality and Repeatability Information

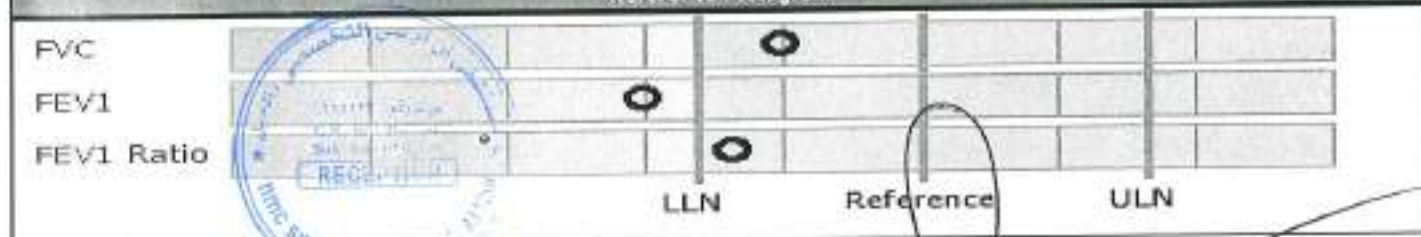
| FVC Session Grade | FVC Rep: | FEV1 Rep: | Slow Start of test | End of test criteria not achieved | Cough detected in 1st second |
|-------------------|----------|-----------|--------------------|-----------------------------------|------------------------------|
| D                 | -        | -         | 1 blow(s)          | 0 blow(s)                         | 0 blow(s)                    |

## Computer Suggested Interpretation

Computer Interpretations cannot be relied upon for diagnosis. Normal ventilatory function.

Estimated Lung Age: 74 years

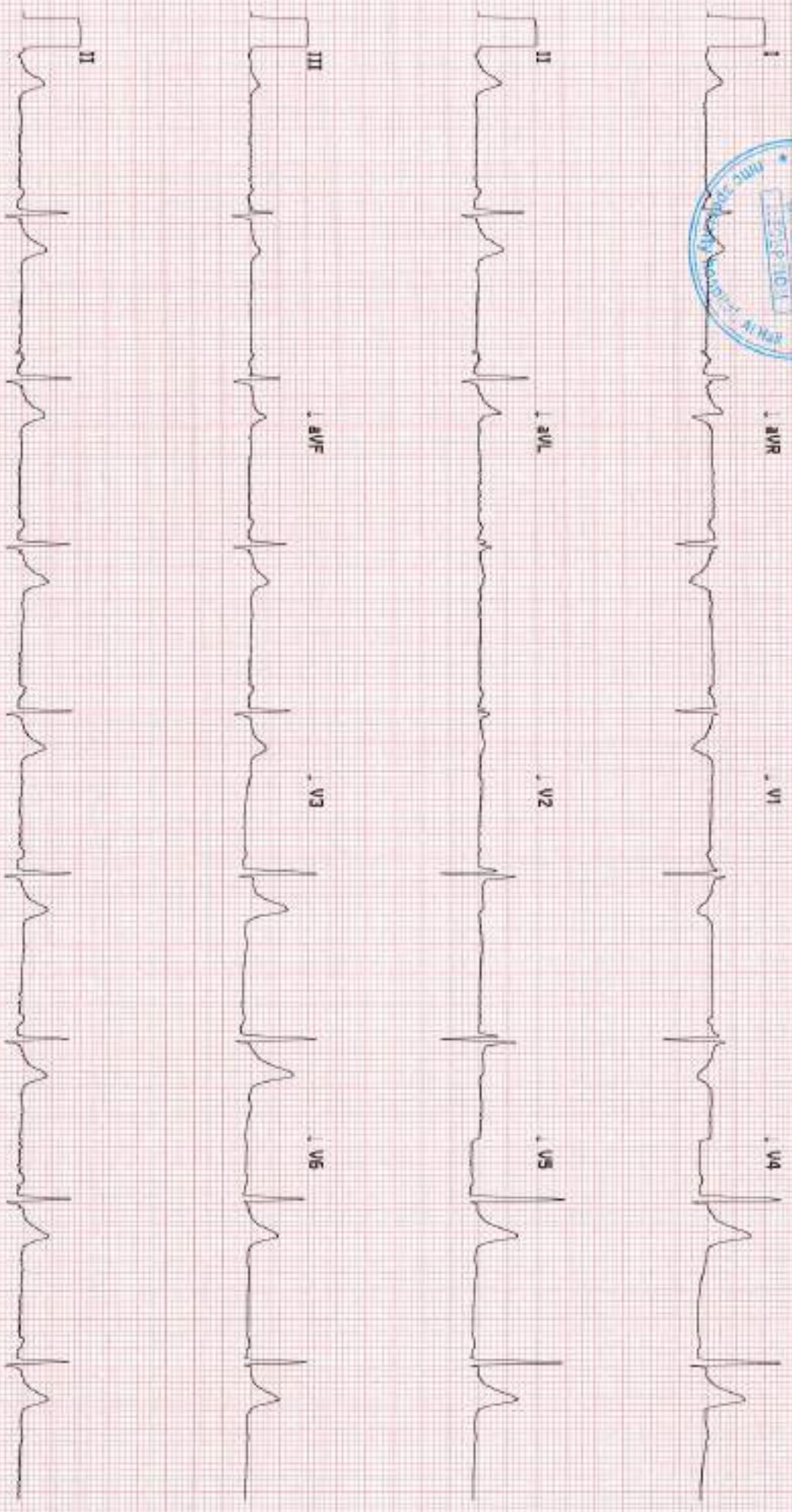
## Reference Pictogram



SHARMA, NACHIN  
ID: 50083797  
DOB:  
34yr, Male

II-32P-2V2L 2.8/2.14  
Vent rate: 52 BPM  
PR Int: 139 ms  
QRS dur: 91 ms  
QT/QTc: 376/357 ms  
P-R-T axes: 47 50 51

SINUS BRADYCARDIA  
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY (RSP (QR) IN V1/V2)  
BORDERLINE ECG  
UNCONFIRMED REPORT



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No Site Name CTBoutura QUINCY

Site # 0 Cart # 0 Version 21.05 Sequence #02138 25mm/s 10mm/mV 0.05-40 Hz M

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