FAX

Recipient name :

White Label Testing Org

Sender name :

WCR Advantage

Subject :

Patient Information

Patient Name	**Madison Coagusense**
Date of Birth	**1997-04-23**

Metric

Date & Time	**2025-10-15 20:54:13**
Test Type	**INR**
Result	**0.7 INR**

Metric

Date & Time	**2025-10-15 20:54:13**
Test Type	**Prothrombin Time**
Result	**9 s**