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	**2025-12-03 22:20:40**
Test Type	**INR**
Result	**1 INR**

Metric

Date & Time	**2025-12-03 22:20:40**
Test Type	**Prothrombin Time**
Result	**12.2 s**