1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Imogen A. Farrow-Baptiste

DOB
01/09/1984

AGE / SEX
42 yrs / Female

MRN / PATIENT ID
9034117

DATE OF SERVICE
08/05/2026

PROVIDER
Rahul Desikan, MD

CREDENTIALS
MD, MPH, FNLA

REFERRAL SOURCE
Primary care — abnormal lipid panel and family history

VISIT TYPE
New Patient Consultation — cardiovascular risk assessment

CARE SETTING
Outpatient Lipid & Preventive Cardiology Clinic

PRIMARY CARE PROVIDER
Denise Alvarado, MD

PRIMARY CARDIOLOGIST
None — first cardiology contact

CC CHIEF COMPLAINT

2 PRIMARY PREVENTIVE CARDIOLOGY CONCERN

"My brother had a heart attack at 44 last spring. My cholesterol has always been called borderline and nobody ever did anything about it. I don't want to be the next one, and I need to know whether this is something I've passed to my children."

S SUBJECTIVE

3 PATIENT-REPORTED RISK FACTORS, LIFESTYLE, FAMILY HISTORY & TREATMENT RESPONSE

3a INDICATION, SYMPTOMS & CARDIOVASCULAR HISTORY

Reason for Preventive Cardiology Evaluation

Primary prevention risk stratification in a 42-year-old woman with a markedly elevated lipoprotein(a), untreated LDL-C in the familial hypercholesterolemia range, a strong family history of premature ASCVD, and two sex-specific risk factors

from an obstetric history of preeclampsia and gestational diabetes. Visit purpose: formal risk assessment, decision on coronary artery calcium scoring, initiation of lipid-lowering therapy after a prior statin intolerance, evaluation for familial hypercholesterolemia, and cascade screening planning.

Cardiovascular Symptoms

Entirely asymptomatic. Denies chest pain or pressure at rest or on exertion, exertional dyspnea beyond what she attributes to deconditioning, palpitations, dizziness, syncope, edema, or claudication. Completes a 5 km charity walk annually without symptoms. No functional decline.

Personal Cardiovascular History

No known coronary artery disease, MI, PCI, CABG, stroke, TIA, peripheral or carotid disease, aortic disease, heart failure, arrhythmia, or valvular disease. No prior stress testing, echocardiography, or cardiac imaging of any kind. An ECG obtained in 2019 for palpitations during a caffeine binge was reported as normal.

Cardiovascular Risk Factors

Stage 1 hypertension diagnosed 2023, untreated to date. Untreated hyperlipidemia known since at least 2014. Prediabetes with an A1c of 6.1% in 2025. BMI 28.7 with a waist circumference of 94 cm. Obstructive sleep apnea suspected but never formally tested — her husband reports witnessed apneas and she has an Epworth score of 12. Sedentary occupation. Preeclampsia in her second pregnancy (2016) requiring induction at 36 weeks, and gestational diabetes in the same pregnancy. Sjögren syndrome diagnosed 2021 on hydroxychloroquine — a chronic inflammatory condition and recognized risk enhancer. Never smoked. No CKD, no HIV, no prior radiation or chemotherapy. Premenopausal with regular cycles.

Family History

Brother, age 44 at event (2025), anterior STEMI with two-vessel disease and PCI — his LDL-C at presentation was 212 mg/dL and his Lp(a) was 168 nmol/L. Father, MI at age 51, died of a second MI at 58. Paternal grandmother, stroke at 62. Mother alive at 71 with hypertension only. Two maternal aunts with hypothyroidism, no lipid disorder. One sister, age 39, never screened. Two children aged 12 and 10, never screened. No known family diagnosis of familial hypercholesterolemia, cardiomyopathy, aortic disease, or sudden cardiac death.

3b LIPID, BLOOD PRESSURE & METABOLIC HISTORY

Lipid History

LDL-C documented at 168 mg/dL in 2014, 181 in 2019, 189 in 2023, and 194 mg/dL on 07/18/2026 — a consistently elevated, untreated trajectory with no secondary cause identified. HDL-C 46, triglycerides 178, total cholesterol 275, non-HDL-C 229 mg/dL. ApoB 148 mg/dL. Lp(a) 214 nmol/L, drawn 07/18/2026 — the first time it has ever been measured. Atorvastatin 20 mg was trialled in 2023 and stopped by her after 5 weeks for bilateral thigh and calf myalgia rated 6/10; no CK was checked at the time and no rechallenge was attempted. She has taken no lipid therapy since. She reports significant apprehension about statins after reading online accounts.

Blood Pressure History

Home readings on a validated upper-arm cuff average 142/88 over two weeks of twice-daily measurement, with a recorded range of 134–154 systolic. Office readings have run 138–150 systolic since 2023. No antihypertensive has ever been prescribed. Dietary sodium is high — she estimates most weekday lunches are takeaway or packaged. No orthostatic symptoms, headaches, or visual change. No prior hypertensive urgency or emergency.

Diabetes / Metabolic History

Prediabetes with A1c 5.9% (2023), 6.1% (2025), and 6.0% on 07/18/2026. History of gestational diabetes in 2016 managed with diet. No diabetes medication. Fasting glucose 108 mg/dL. Weight has risen 9 kg over six years, with the steepest gain in the two years since her Sjögren diagnosis and the associated fatigue. Waist circumference 94 cm, triglycerides 178, HDL-C 46, blood pressure 142/88, fasting glucose 108 — four of five metabolic syndrome criteria are met. No diabetic complications.

3c LIFESTYLE, SUBSTANCE USE & PRIOR TESTING

Lifestyle and Nutrition

Breakfast frequently skipped; weekday lunch is takeaway four to five times weekly; family evening meals are home-cooked but heavy on red meat and full-fat dairy. Estimated saturated fat intake well above 10% of calories. Fibre intake low at an

estimated 12 g daily. Two to three sweetened beverages daily, primarily sweetened iced coffee. Sodium intake estimated at 4–5 g. Alcohol two to three glasses of wine weekly. Caffeine four cups daily. No prior nutrition counselling. She reports she is “ready to change the food, but needs a plan, not a lecture.”

Physical Activity / Fitness

Approximately 40 minutes of walking weekly in total, well below guideline targets. No resistance training. Sedentary for nine to ten hours daily as a paralegal. Barriers cited are Sjögren-related fatigue, two children’s schedules, and a 55-minute commute. Functional capacity is preserved — she completes a 5 km walk annually without symptoms. No cardiac rehab history. No activity-related chest pain or dyspnea.

Tobacco / Nicotine / Substance Use

Never smoked. No vaping, smokeless tobacco, or nicotine pouches. No cannabis, stimulant, or recreational drug use. Alcohol as described, well within recommended limits.

Medication History and Treatment Response

Current: hydroxychloroquine 300 mg daily, pilocarpine as needed for xerostomia, cetirizine 10 mg daily, and a multivitamin. Prior: atorvastatin 20 mg 2023, discontinued for myalgia after 5 weeks without CK measurement or rechallenge. No ezetimibe, PCSK9 inhibitor, inclisiran, bempedoic acid, or omega-3 therapy has been tried. No antihypertensive, aspirin, diabetes medication, or weight-loss medication. Insurance is commercial with a specialty tier; no current affordability barrier identified.

Prior Testing / Risk Assessment

No coronary artery calcium score, coronary CTA, stress test, echocardiogram, carotid imaging, or ABI has ever been performed. No prior Lp(a) or ApoB before 07/2026. No genetic testing. No sleep study despite symptoms.

Pertinent Negatives

Denies chest pain, exertional pressure, dyspnea at rest, orthopnea, syncope, presyncope, focal neurologic symptoms, transient visual loss, speech disturbance, claudication or rest limb pain, and worsening edema. No acute cardiovascular symptoms of any kind.

ROS PREVENTIVE CARDIOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Chest pain, exertional symptoms, dyspnea, palpitations, dizziness, or syncope	**Negative throughout.**
Edema, orthopnea, reduced exercise tolerance, or claudication	**Negative. Reduced activity is volitional and fatigue-related, not symptom-limited.**
Headache, vision changes, neurologic symptoms, or stroke / TIA symptoms	**Negative.**
Medication side effects, statin-associated symptoms, myalgias, or intolerance concerns	**Positive — bilateral proximal myalgia on atorvastatin 20 mg in 2023, no CK checked, no rechallenge. Significant statin apprehension.**
Weight change, fatigue, sleep apnea symptoms, or metabolic symptoms	**Positive — 9 kg gain over 6 years, daytime fatigue with Epworth 12, witnessed apneas, dry eyes and mouth from Sjögren.**
Tobacco, alcohol, stimulant, caffeine, diet, or exercise-related risk factors	**Positive for diet, sedentary time, and sweetened beverages. Never smoked; alcohol within limits.**
Bleeding or bruising if aspirin or anticoagulant therapy is used	**Not applicable — on no antithrombotic therapy.**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
36.6 °C	144/90 mmHg (average of 2 readings, correct cuff)
HEART RATE	RESPIRATORY RATE
76 bpm, regular	14 /min
OXYGEN SATURATION	HEIGHT
99% on room air	165 cm
WEIGHT	BMI
78.2 kg	28.7 kg/m²
WAIST CIRCUMFERENCE	ORTHOSTATIC VITALS
94 cm	Not indicated — asymptomatic, not on antihypertensive therapy

5a GENERAL, CARDIOVASCULAR & PULMONARY

General Appearance

Well-appearing, comfortable, in no distress. Central adiposity with an android fat distribution. Fully functional and independent.

Cardiovascular

Rate 76, regular rhythm. Normal S1 and S2, no murmur, rub, or gallop. JVP not elevated. No carotid bruits on either side. Radial, femoral, dorsalis pedis, and posterior tibial pulses all 2+ and symmetric. Capillary refill under 2 seconds. No peripheral edema.

Pulmonary

Clear to auscultation bilaterally. Normal work of breathing. No crackles or wheeze. Room air.

5b ABDOMEN, VASCULAR, SKIN & NEUROLOGIC

Abdomen

Central adiposity as noted. Soft and non-tender. No hepatomegaly appreciated. No abdominal or renal bruit.

Extremities / Vascular

Pulses intact and symmetric throughout. No edema, cyanosis, or clubbing. No varicosities, ulceration, or trophic change. No findings of peripheral arterial or venous disease.

Skin

No xanthelasma. **Bilateral Achilles tendon thickening is present**, symmetric and non-tender, with a measured tendon width of approximately 9 mm on both sides — a physical sign strongly supporting familial hypercholesterolemia. No eruptive or tuberous xanthomas. Mild acanthosis nigricans at the posterior neck. Dry mucous membranes consistent with Sjögren. No surgical scars.

Neurologic

Alert and oriented. Cranial nerves intact. No focal motor or sensory deficit. Normal gait.

RA CARDIOMETABOLIC RISK ASSESSMENT

6 CARDIOVASCULAR RISK PROFILE & RISK-ENHANCING FACTORS

ASCVD RISK ESTIMATE

10-year pooled cohort risk 3.9% (low) — substantially underestimates true risk in this patient

PRIMARY VERSUS SECONDARY PREVENTION

Primary prevention

CORONARY ARTERY CALCIUM SCORE

Not yet performed — ordered today

LDL-C AND NON-HDL-C BURDEN

LDL-C 194 mg/dL; non-HDL-C 229 mg/dL — untreated for at least 12 years

APOB AND LP(A) STATUS

ApoB 148 mg/dL (>90th percentile); Lp(a) 214 nmol/L (>90th percentile)

BLOOD PRESSURE CONTROL STATUS

Stage 2 hypertension, untreated — home average 142/88, office 144/90

DIABETES OR PREDIABETES STATUS

Prediabetes, A1c 6.0%; prior gestational diabetes

METABOLIC SYNDROME FEATURES

4 of 5 criteria met — waist, triglycerides, HDL-C, blood pressure, fasting glucose

OBESITY CLASS OR WEIGHT-RELATED RISK

Overweight, BMI 28.7, with central adiposity at a waist of 94 cm

TOBACCO / NICOTINE EXPOSURE

None — lifelong never-smoker

Family history of premature ASCVD

Strongly positive — brother with STEMI at 44, father with MI at 51 and cardiac death at 58. Both events fall well within the premature ASCVD definition, and the brother's Lp(a) of 168 nmol/L confirms a heritable lipoprotein(a) trait segregating in the family.

CKD, inflammatory disease, autoimmune disease, or other risk-enhancing conditions

Sjögren syndrome since 2021 — a chronic inflammatory autoimmune condition and a guideline-recognized risk enhancer. No CKD; eGFR 94. Suspected untreated obstructive sleep apnea with an Epworth of 12 and witnessed apneas.

Pregnancy-related or sex-specific risk factors

Two sex-specific risk enhancers — preeclampsia requiring induction at 36 weeks in 2016, and gestational diabetes in the same pregnancy. Both are independently associated with a roughly two-fold long-term ASCVD risk and are absent from the pooled cohort equations. Premenopausal with regular cycles.

Lifestyle risk factors and readiness for change

High saturated fat and sodium intake, low fibre, two to three sweetened beverages daily, and roughly 40 minutes of weekly activity. She is at the preparation stage — explicitly motivated by her brother's infarct, asking for a structured plan, and receptive to referral. Statin apprehension is the principal barrier to pharmacotherapy and is addressable.

L CARDIAC TESTING / DIAGNOSTIC RESULTS

7 RESULTS REVIEWED OR ORDERED

Lipid Testing — 07/18/2026

Total cholesterol 275 mg/dL, LDL-C 194 (direct), HDL-C 46, triglycerides 178, non-HDL-C 229, ApoB 148 mg/dL, Lp(a) 214

nmol/L. Historical LDL-C trend: 168 (2014), 181 (2019), 189 (2023), 194 (2026).

Metabolic Labs — 07/18/2026

HbA1c 6.0%, fasting glucose 108 mg/dL. CMP normal with creatinine 0.78 and eGFR 94. ALT 26, AST 22. Urine albumin-to-creatinine ratio 9 mg/g. TSH 2.4 with normal free T4 — hypothyroidism excluded as a secondary cause. Uric acid 5.8. hs-CRP 3.4 mg/L. Total CK 118 U/L (normal), drawn today as a baseline before any statin rechallenge.

Cardiac Risk Testing

Coronary artery calcium score ordered today — the decisive test in this case, given a discordance between a low calculated risk and a heavy risk-enhancer burden. No prior stress testing, coronary CTA, echocardiography, ABI, or carotid imaging. ABI deferred as asymptomatic with normal pulses.

Medication Monitoring

Baseline CK 118 U/L and hepatic panel normal, both obtained today to anchor the planned statin rechallenge and to allow objective evaluation should myalgia recur. Renal function and potassium normal ahead of antihypertensive initiation.

Genetic / Familial Risk Testing

Dutch Lipid Clinic Network score calculated at 11 points — untreated LDL-C 194 mg/dL (5 points), first-degree relative with premature coronary disease (1 point), tendon xanthomata on examination (6 points, capped at the criterion) — placing her in the *definite* familial hypercholesterolemia category. Genetic panel for *LDLR*, *APOB*, and *PCSK9* ordered today with pre-test counselling documented.

Sleep / Lifestyle-Related Testing

Home sleep apnea test ordered for an Epworth of 12 with witnessed apneas, central adiposity, and hypertension. No prior body composition or exercise testing.

Prior Records Reviewed

Primary care records 2014–2026 with the full lipid trend, obstetric records from the 2016 pregnancy confirming preeclampsia and gestational diabetes, rheumatology notes documenting Sjögren syndrome and hydroxychloroquine therapy, and — with written consent — her brother's 2025 catheterization report and lipid panel. Approximately 21 minutes of independent record review.

A ASSESSMENT

8 PREVENTIVE CARDIOLOGY CLINICAL INTERPRETATION

- **Definite heterozygous familial hypercholesterolemia** by Dutch Lipid Clinic Network criteria, score 11. Untreated LDL-C of 194 mg/dL sustained over at least twelve years, bilateral Achilles tendon thickening on examination, and a first-degree relative with premature coronary disease. This is a lifetime cumulative-exposure disease, and twelve years of documented untreated LDL burden is the central finding of this consultation.
- **Markedly elevated lipoprotein(a) at 214 nmol/L** — above the 90th percentile and an independent, genetically determined, largely diet- and exercise-unresponsive risk factor. Her brother's Lp(a) of 168 nmol/L confirms the trait is segregating in the family. Elevated Lp(a) co-inherited with FH is a well-described multiplicative risk combination.
- **The calculated 10-year risk of 3.9% is misleading and should not guide therapy here.** The pooled cohort equations do not incorporate Lp(a), familial hypercholesterolemia, preeclampsia, gestational diabetes, or systemic autoimmune inflammation — she carries all five. Her lifetime risk is high, and treatment decisions should be anchored to that.
- **Untreated stage 2 hypertension** — home average 142/88 over two weeks of validated monitoring, office 144/90, no antihypertensive ever prescribed. This warrants pharmacotherapy in its own right.

- **Prediabetes with metabolic syndrome**, meeting four of five criteria, on a background of gestational diabetes. Progression risk to type 2 diabetes is substantial and modifiable.
- **Statin intolerance is unproven.** A single 5-week trial of atorvastatin 20 mg in 2023, discontinued for myalgia with no CK measured, no washout, and no rechallenge. This does not meet any accepted definition of statin intolerance, and she should not be denied first-line therapy on that basis.
- **Two sex-specific risk enhancers** — preeclampsia and gestational diabetes in the 2016 pregnancy — that have never previously been carried forward into her cardiovascular risk assessment.
- **Sjögren syndrome** as a chronic inflammatory risk enhancer, with an hs-CRP of 3.4 mg/L consistent with a low-grade inflammatory burden.
- **Probable untreated obstructive sleep apnea**, contributing to both blood pressure and metabolic risk, never formally tested.
- **Coronary artery calcium scoring is the pivotal next test.** A score above zero in a 42-year-old woman would place her at the high end of age- and sex-matched risk and remove any remaining ambiguity about treatment intensity. A score of zero would not change the decision to treat given definite FH, but it would inform intensity and imaging cadence.
- **Cascade screening is a priority.** One sister aged 39 and two children aged 12 and 10 are all unscreened first-degree relatives of a patient with definite FH.

P PLAN

9 PREVENTIVE CARDIOLOGY MANAGEMENT BY PROBLEM

- **Lipid-lowering therapy — initiate today:** rosuvastatin 10 mg daily, deliberately chosen as a different agent from her 2023 atorvastatin trial, at a modest starting dose, with a hydrophilic profile that is often better tolerated. Baseline CK of 118 documented. Uptitrate to 20 mg at 6 weeks if tolerated. Target LDL-C reduction of at least 50% from the untreated baseline of 194 mg/dL, aiming for under 100 mg/dL and ideally under 70 mg/dL given the FH and Lp(a) combination.
- **Statin tolerance strategy:** the 2023 trial explicitly reframed for her as inconclusive rather than as proven intolerance. Agreed plan discussed in full: if myalgia recurs, stop and check CK, allow a 2-week washout, then rechallenge at an alternate-day dose before ever declaring intolerance. Written instructions provided. Vitamin D and thyroid already excluded as contributors.
- **Combination therapy:** add ezetimibe 10 mg daily at the 6-week visit if LDL-C remains above 100 mg/dL. If LDL-C remains above 100 mg/dL on maximally tolerated statin plus ezetimibe at 3 months, proceed to PCSK9 inhibitor authorization — definite FH with an Lp(a) above 200 nmol/L supports that request, and the documentation has been structured accordingly.
- **Lipoprotein(a):** counselled that Lp(a) is genetically set, does not respond meaningfully to diet or exercise, and needs measuring only once in a lifetime. It does not change today's therapy, but it raises the aggressiveness of the LDL-C target and it is the reason cascade screening matters. Emerging Lp(a)-lowering agents discussed and clinical trial eligibility to be revisited at follow-up.
- **Blood pressure:** initiate perindopril 4 mg daily for stage 2 hypertension with a target below 130/80. BMP in 2 weeks to check creatinine and potassium. Home monitoring to continue twice daily with a written log. Reproductive counselling documented — she is premenopausal, so contraception and the need to stop the ACE inhibitor before any future pregnancy were discussed explicitly.
- **Coronary artery calcium scoring:** ordered, to be completed within 4 weeks, with results to guide treatment intensity and the imaging cadence thereafter.

- **Genetic testing and cascade screening:** *LDLR*, *APOB*, and *PCSK9* panel sent today with pre-test counselling documented. Formal genetic counselling referral placed. Cascade lipid screening recommended for her sister (age 39) now, and for both children (ages 12 and 10) — the paediatric screening request has been routed to Dr. Alvarado, and family letters were provided.
- **Nutrition:** registered dietitian referral placed with a Mediterranean-pattern target. Concrete agreed goals set today: saturated fat below 7% of calories, sodium below 2.3 g, fibre above 25 g daily, and elimination of sweetened beverages with a stepwise reduction from three to one to zero over six weeks. She was given a plan rather than a lecture, at her request.
- **Exercise:** stepwise target of 150 minutes of moderate aerobic activity weekly, starting at 20 minutes three times weekly and adding 5 minutes weekly, plus resistance training twice weekly from week 4. Commute-based walking and stair use identified with her as the practical entry point. No exercise testing required before starting, as she is asymptomatic with preserved functional capacity.
- **Metabolic risk:** A1c and fasting glucose repeated at 3 months. Weight-loss target of 5–7% of body weight, approximately 4–5.5 kg. If A1c reaches 6.3% or above, or weight goals are not met by 6 months, refer for GLP-1 receptor agonist consideration through primary care.
- **Sleep apnea:** home sleep apnea test ordered, with sleep medicine referral to follow if positive.
- **Aspirin:** not indicated. Primary prevention with no coronary calcium data and no compelling high-risk marker at present — the bleeding risk is not justified. To be revisited only if the calcium score is markedly elevated.
- **Coordination:** note routed to Dr. Alvarado and to rheumatology. Referrals placed to dietetics, genetic counselling, and sleep medicine. Paediatric lipid screening request routed for both children.
- **Patient education:** 26 minutes of counselling on FH as a lifetime cumulative-exposure disease, why her calculated risk score understates her true risk, the meaning of Lp(a), the statin rechallenge plan and why her 2023 experience does not close the door, cascade screening for her sister and children, and the specific dietary and activity targets agreed today. Written after-visit summary and a family screening letter provided.

F FOLLOW-UP

10 REASSESSMENT PLAN

Follow-up timeframe and purpose

Preventive cardiology clinic in 6 weeks (09/16/2026) for lipid panel, hepatic panel, and CK if symptomatic; rosuvastatin tolerance and uptitration decision; coronary artery calcium score review; blood pressure log review; and genetic result disclosure. BMP in 2 weeks after perindopril initiation. A1c, fasting glucose, and weight at 3 months. Repeat ApoB at 3 months as the treatment target marker. Lp(a) requires no repeat testing. Sister and children to be screened before the next visit. She was instructed to contact the clinic for muscle pain with dark urine, chest pain, exertional symptoms, or a home systolic reading above 180.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT
60 minutes

COUNSELING / LIFESTYLE COUNSELING TIME
26 minutes

CARE COORDINATION TIME
9 minutes — dietetics, genetics, sleep medicine, paediatric screening

RECORDS REVIEW TIME
21 minutes

RISK ASSESSMENT / TEST REVIEW TIME
11 minutes — DLCN scoring, lipid trend, family lipid data

BASIS FOR BILLING
Medical Decision Making (high complexity)

E/M LEVEL
99205 — new patient, high MDM

PREVENTIVE COUNSELING CODE(S)
99401 — preventive medicine counseling, 15 minutes (not separately billed; bundled into time)

DIAGNOSTIC TEST INTERPRETATION CODE(S)
None — coronary calcium score pending

PRIMARY ICD-10 DIAGNOSIS CODE
E78.01 — Familial hypercholesterolemia

SECONDARY ICD-10 DIAGNOSIS CODE(S)
E78.41 — Elevated lipoprotein(a); I10 — Essential hypertension; R73.03 — Prediabetes; E88.81 — Metabolic syndrome; E66.3 — Overweight; M35.00 — Sjögren syndrome, unspecified; Z87.51 — Personal history of pre-term labor; O09.929 — History of preeclampsia (documented); Z82.49 — Family history of ischemic heart disease; Z13.6 — Encounter for screening for cardiovascular disorders

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Rahul Desikan, MD	MD, MPH, FNLA	Preventive Cardiology / Clinical Lipidology	08/05/2026	9:55 AM