

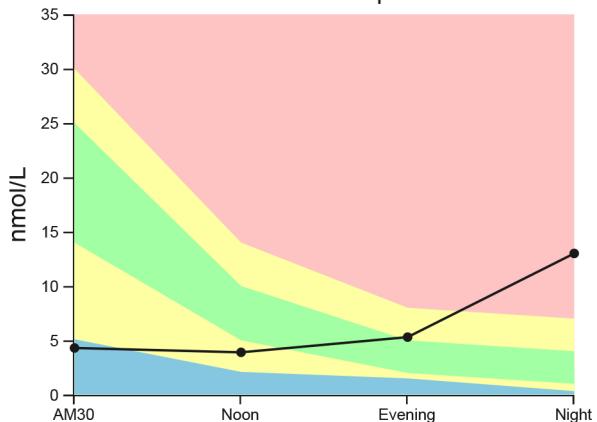
**Order: SAMPLE REPORT****Client #:** 12345

**Doctor:** Sample Doctor, MD  
Doctors Data Inc.  
3755 Illinois Ave.  
St. Charles, IL 60174

**Patient: Sample Report****Age:** 33**Sex:** Female**Body Mass Index (BMI):** N/A**Menopausal Status:** Pre-Menopausal**Sample Collection**

	<b>Date/Time</b>
<b>Date Collected</b>	10/01/2018
AM30	10/01/2018 0800
Noon	10/01/2018 1200
Evening	10/01/2018 1700
Night	10/01/2018 2100
<b>Date Received</b>	10/03/2018
<b>Date Reported</b>	10/05/2018

<b>Analyte</b>	<b>Result</b>	<b>Unit</b>	<b>L</b>	<b>WRI</b>	<b>H</b>	<b>Optimal Range</b>	<b>Reference Interval</b>
<b>Cortisol AM30</b>	4.3	nmol/L				14.0 - 25.0	5.1 - 30.0
<b>Cortisol Noon</b>	3.9	nmol/L				5.0 - 10.0	2.1 - 14.0
<b>Cortisol Evening</b>	5.3	nmol/L				2.0 - 5.0	1.5 - 8.0
<b>Cortisol Night</b>	13	nmol/L				1.0 - 4.0	0.33 - 7.0
<b>DHEA*</b>	89	pg/mL					106 - 300

**Cortisol Graph****Adrenal Phase: 1****Hormone Comments:**

- The elevated night cortisol level and diurnal pattern are consistent with hypothalamic pituitary axis (HPA) dysregulation (Phase 1), although cortisol or glucocorticoid derivative supplementation cannot be excluded. Query use of steroid inhalers or topical creams. High night cortisol levels are associated with low melatonin levels.
- DHEA level is consistent with the expected decline with age (adrenopause). The low DHEA level may warrant supplementation for optimal well-being. Note: Supplementation with DHEA may increase testosterone and/or estradiol levels.

**Notes:**

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Analyte	Result	Unit	L	WRI	H	Reference Interval	Supplementation Range**
<b>Estrone (E1)*</b>	20.0	pg/mL				< 45	
<b>Estradiol (E2)</b>	1.9	pg/mL				0.5 - 5.0	1.5 - 7.2
<b>Estriol (E3)*</b>	17.9	pg/mL				< 66	67 - 708
<b>EQ (E3 / (E1 + E2)) Ratio</b>	0.80					> 1.0	
<b>Progesterone (Pg)</b>	36	pg/mL				127 - 446	500 - 3000
<b>Pg/E2 Ratio</b>	18.9					200 - 600	
<b>Testosterone</b>	25	pg/mL				6.0 - 49	30 - 60
<b>DHEA*</b>	89	pg/mL				106 - 300	

**Hormone Comments:**

- Estrone, estradiol and estriol are within the reference ranges, however the Estrogen Quotient (EQ) is low. Estriol is less potent than the other estrogens and when present in sufficient quantities (as indicated by an optimal EQ) it plays an antagonistic role, and may govern the proliferative effects of estrone and estradiol. Estriol supplementation is a consideration to balance this quotient and reduce associated risks.
- Progesterone to estradiol (Pg/E2) ratio and reported symptoms are consistent with progesterone insufficiency (estrogen dominance). Supplementation with topical progesterone to correct this relative deficiency is a consideration. Note: The progesterone level is suggestive of an anovulatory cycle, luteal phase failure or collection outside of luteal phase.
- DHEA level is consistent with the expected decline with age (adrenopause). The low DHEA level may warrant supplementation for optimal well-being. Note: Supplementation with DHEA may increase testosterone and/or estradiol levels.

**Notes:**

RI= Reference Interval, L (blue)= Low (below RI), WRI (green)= Within RI (optimal), WRI (yellow)= Within RI (not optimal), H (red)= High (above RI)

The current samples are routinely held three weeks from receipt for additional testing.

The Pg/E2 ratio is an optimal range established based on clinical observation. Progesterone supplementation is generally required to achieve this level in men and postmenopausal women.