Quest Diagnostics

Report Status: Final

Patient Information	Specimen Information	Client Information
DOB: **AGE:** Gender: Phone: Patient ID:	Specimen: Requisition: Collected: Received: Reported:	

COMMENTS: FASTING:YES

Test Name	In Range	Out Of Range	Reference Range	Lab
LIPID PANEL, STANDARD				
CHOLESTEROL, TOTAL		**218 H**	<200 mg/dL	
HDL CHOLESTEROL	75		>40 mg/dL	
TRIGLYCERIDES	75		<150 mg/dL	
LDL-CHOLESTEROL		**126 H**	mg/dL (calc)	

Reference range: <100

Desirable range <100 mg/dL for primary prevention;
<70 mg/dL for patients with CHD or diabetic patients
with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins
calculation, which is a validated novel method providing
better accuracy than the Friedewald equation in the
estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068
(http://education.QuestDiagnostics.com/faq/FAQ164)

CHOL/HDLC RATIO	2.9		<5.0 (calc)	
NON HDL CHOLESTEROL		**143 H**	<130 mg/dL (calc)	

For patients with diabetes plus 1 major ASCVD risk
factor, treating to a non-HDL-C goal of <100 mg/dL
(LDL-C of <70 mg/dL) is considered a therapeutic
option.

HS CRP	<0.2		mg/L	

Verified by repeat analysis.

Lower relative cardiovascular risk according to
AHA/CDC guidelines.

For ages >17 Years:

hs-CRP mg/L	Risk According to AHA/CDC Guidelines
<1.0	Lower relative cardiovascular risk.
1.0-3.0	Average relative cardiovascular risk.
3.1-10.0	Higher relative cardiovascular risk. Consider retesting in 1 to 2 weeks to exclude a benign transient elevation in the baseline CRP value secondary to infection or inflammation.
>10.0	Persistent elevation, upon retesting, may be associated with infection and inflammation.

HOMOCYSTEINE		**11.4 H**	<11.4 umol/L	

Homocysteine is increased by functional deficiency of
folate or vitamin B12. Testing for methylmalonic acid
differentiates between these deficiencies. Other causes
of increased homocysteine include renal failure, folate
antagonists such as methotrexate and phenytoin, and
exposure to nitrous oxide.

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COMPREHENSIVE METABOLIC PANEL				
GLUCOSE	98		65-99 mg/dL Fasting reference interval	
UREA NITROGEN (BUN)	12		7-25 mg/dL	
CREATININE	0.98		0.60-1.35 mg/dL	
eGFR NON-AFR. AMERICAN	92		> OR = 60 mL/min/1.73m2	
eGFR AFRICAN AMERICAN	107		> OR = 60 mL/min/1.73m2	
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM		**133 L**	135-146 mmol/L	
POTASSIUM	4.2		3.5-5.3 mmol/L	
CHLORIDE	99		98-110 mmol/L	
CARBON DIOXIDE	28		20-32 mmol/L	
CALCIUM	9.5		8.6-10.3 mg/dL	
PROTEIN, TOTAL	7.1		6.1-8.1 g/dL	
ALBUMIN	4.4		3.6-5.1 g/dL	
GLOBULIN	2.7		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.6		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.7		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	54		40-115 U/L	
AST	20		10-40 U/L	
ALT	20		9-46 U/L	
HEMOGLOBIN A1c	5.6		<5.7 % of total Hgb	

For the purpose of screening for the presence of diabetes:

<5.7% Consistent with the absence of diabetes
5.7-6.4% Consistent with increased risk for diabetes (prediabetes)
> or =6.5% Consistent with diabetes

This assay result is consistent with a decreased risk of diabetes.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes in children.

According to American Diabetes Association (ADA) guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes(ADA).

TSH	1.56		0.40-4.50 mIU/L	
FIBRINOGEN ACTIVITY, CLAUSS	215		175-425 mg/dL	
CBC (INCLUDES DIFF/PLT)				
WHITE BLOOD CELL COUNT	5.0		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.48		4.20-5.80 Million/uL	
HEMOGLOBIN	13.2		13.2-17.1 g/dL	
HEMATOCRIT	40.3		38.5-50.0 %	
MCV	90.0		80.0-100.0 fL	
MCH	29.5		27.0-33.0 pg	
MCHC	32.8		32.0-36.0 g/dL	

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RDW	13.2		11.0-15.0 %	
PLATELET COUNT	206		140-400 Thousand/uL	
MPV	10.5		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	2450		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	1890		850-3900 cells/uL	
ABSOLUTE MONOCYTES	540		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	80		15-500 cells/uL	
ABSOLUTE BASOPHILS	40		0-200 cells/uL	
NEUTROPHILS	49		%	
LYMPHOCYTES	37.8		%	
MONOCYTES	10.8		%	
EOSINOPHILS	1.6		%	
BASOPHILS	0.8		%	
DHEA SULFATE	196		70-495 mcg/dL	

DHEA-S values fall with advancing age.
For reference, the reference intervals for 31-40 year old patients are:

Male: 106-464 mcg/dL
Female: 23-266 mcg/dL

ESTRADIOL	<15		< OR = 39 pg/mL	

Reference range established on post-pubertal patient population. No pre-pubertal reference range established using this assay. For any patients for whom low Estradiol levels are anticipated (e.g. males, pre-pubertal children and hypogonadal/post-menopausal females), the Quest Diagnostics Nichols Institute Estradiol, Ultrasensitive, LCMSMS assay is recommended (order code 30289).

Please note: patients being treated with the drug fulvestrant (Faslodex(R)) have demonstrated significant interference in immunoassay methods for estradiol measurement. The cross reactivity could lead to falsely elevated estradiol test results leading to an inappropriate clinical assessment of estrogen status. Quest Diagnostics order code 30289-Estradiol, Ultrasensitive LC/MS/MS demonstrates negligible cross reactivity with fulvestrant.

PSA, TOTAL	1.4		< OR = 4.0 ng/mL	

The total PSA value from this assay system is standardized against the WHO standard. The test result will be approximately 20% lower when compared to the equimolar-standardized total PSA (Beckman Coulter). Comparison of serial PSA results should be interpreted with this fact in mind.

This test was performed using the Siemens chemiluminescent method. Values obtained from different assay methods cannot be used interchangeably. PSA levels, regardless of value, should not be interpreted as absolute evidence of the presence or absence of disease.

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TESTOSTERONE, FREE (DIALYSIS) AND TOTAL,MS				
TESTOSTERONE, TOTAL, MS	392		250-1100 ng/dL	
TESTOSTERONE, FREE	83.4		35.0-155.0 pg/mL	

**Data from J Clin Invest 1974:53:819-828 and J Clin Endocrinol Metab 1973;36:1132-1142. Men with clinically significant hypogonadal symptoms and testosterone values repeatedly in the range of the 200-300 ng/dL or less, may benefit from testosterone treatment after adequate risk and benefits counseling.

For additional information, please refer to http://education.questdiagnostics.com/faq/FAQ165 (This link is being provided for informational/ educational purposes only.)

This test was developed and its analytical performance characteristics have been determined by Quest Diagnostics Nichols Institute Valencia. It has not been cleared or approved by the US Food and Drug Administration. This assay has been validated pursuant to the CLIA regulations and is used for clinical purposes.

PERFORMING SITE: