

General Comments & Additional Information

Alternate Control Number: B0036689154

Total Volume: Not Provided

Alternate Patient ID: Not Provided

Fasting: Yes

Ordered Items

CBC With Differential/Platelet; Comp. Metabolic Panel (14); Lipid Panel w/ Chol/HDL Ratio; Testosterone, Free and Total; DHEA-Sulfate; TSH; Prostate-Specific Ag, Serum; Estradiol, Sensitive; Sex Horm Binding Glob, Serum; Venipuncture; Cardiovascular Report

| TESTS | RESULT | FLAG | UNITS | REFERENCE INTERVAL | LAB |
|---------------------------------------|--------|------|-------------|--------------------|-----|
| CBC With Differential/Platelet | | | | | |
| WBC | 6.4 | | x10E3/uL | 3.4 - 10.8 | 01 |
| RBC | 5.69 | | x10E6/uL | 4.14 - 5.80 | 01 |
| Hemoglobin | 16.9 | | g/dL | 12.6 - 17.7 | 01 |
| Hematocrit | 49.5 | | % | 37.5 - 51.0 | 01 |
| MCV | 87 | | fL | 79 - 97 | 01 |
| MCH | 29.7 | | pg | 26.6 - 33.0 | 01 |
| MCHC | 34.1 | | g/dL | 31.5 - 35.7 | 01 |
| RDW | 14.1 | | % | 12.3 - 15.4 | 01 |
| Platelets | 216 | | x10E3/uL | 150 - 379 | 01 |
| Neutrophils | 54 | | % | | 01 |
| Lymphs | 35 | | % | | 01 |
| Monocytes | 8 | | % | | 01 |
| Eos | 2 | | % | | 01 |
| Basos | 1 | | % | | 01 |
| Neutrophils (Absolute) | 3.4 | | x10E3/uL | 1.4 - 7.0 | 01 |
| Lymphs (Absolute) | 2.3 | | x10E3/uL | 0.7 - 3.1 | 01 |
| Monocytes (Absolute) | 0.5 | | x10E3/uL | 0.1 - 0.9 | 01 |
| Eos (Absolute) | 0.1 | | x10E3/uL | 0.0 - 0.4 | 01 |
| Baso (Absolute) | 0.0 | | x10E3/uL | 0.0 - 0.2 | 01 |
| Immature Granulocytes | 0 | | % | | 01 |
| Immature Grans (Abs) | 0.0 | | x10E3/uL | 0.0 - 0.1 | 01 |
| Comp. Metabolic Panel (14) | | | | | |
| Glucose, Serum | 104 | High | mg/dL | 65 - 99 | 01 |
| BUN | 17 | | mg/dL | 6 - 20 | 01 |
| Creatinine, Serum | 1.01 | | mg/dL | 0.76 - 1.27 | 01 |
| eGFR If NonAfricn Am | 99 | | mL/min/1.73 | >59 | |
| eGFR If Africn Am | 114 | | mL/min/1.73 | >59 | |

Date Issued: 02/24/16 0929 ET

FINAL REPORT

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| TESTS | RESULT | FLAG | UNITS | REFERENCE INTERVAL | LAB |
|--|--------|------|-------------|--------------------|-----|
| BUN/Creatinine Ratio | 17 | | | 8 - 19 | |
| Sodium, Serum | 140 | | mmol/L | 134 - 144 | 01 |
| Potassium, Serum | 4.4 | | mmol/L | 3.5 - 5.2 | 01 |
| Chloride, Serum | 97 | | mmol/L | 97 - 108 | 01 |
| Carbon Dioxide, Total | 25 | | mmol/L | 18 - 29 | 01 |
| Calcium, Serum | 9.7 | | mg/dL | 8.7 - 10.2 | 01 |
| Protein, Total, Serum | 6.8 | | g/dL | 6.0 - 8.5 | 01 |
| Albumin, Serum | 4.7 | | g/dL | 3.5 - 5.5 | 01 |
| Globulin, Total | 2.1 | | g/dL | 1.5 - 4.5 | |
| A/G Ratio | 2.2 | | | 1.1 - 2.5 | |
| Bilirubin, Total | 0.6 | | mg/dL | 0.0 - 1.2 | 01 |
| Alkaline Phosphatase, S | 53 | | IU/L | 39 - 117 | 01 |
| AST (SGOT) | 21 | | IU/L | 0 - 40 | 01 |
| ALT (SGPT) | 18 | | IU/L | 0 - 44 | 01 |
| Lipid Panel w/ Chol/HDL Ratio | | | | | |
| Cholesterol, Total | 142 | | mg/dL | 100 - 199 | 01 |
| Triglycerides | 68 | | mg/dL | 0 - 149 | 01 |
| HDL Cholesterol | 64 | | mg/dL | >39 | 01 |
| Comment | | | | | 01 |
| According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD. | | | | | |
| VLDL Cholesterol Calc | 14 | | mg/dL | 5 - 40 | |
| LDL Cholesterol Calc | 64 | | mg/dL | 0 - 99 | |
| T. Chol/HDL Ratio | 2.2 | | ratio units | 0.0 - 5.0 | |
| Please Note: | | | | | 01 |
| T. Chol/HDL Ratio | | | | | |
| Men Women | | | | | |
| 1/2 Avg.Risk 3.4 3.3 | | | | | |
| Avg.Risk 5.0 4.4 | | | | | |
| 2X Avg.Risk 9.6 7.1 | | | | | |
| 3X Avg.Risk 23.4 11.0 | | | | | |
| Testosterone, Free and Total | | | | | |
| Testosterone, Serum | 1067 | | ng/dL | 348 - 1197 | 01 |
| Comment: | | | | | |
| Adult male reference interval is based on a population of lean males up to 40 years old. | | | | | |
| Free Testosterone (Direct) | 35.2 | High | pg/mL | 8.7 - 25.1 | 02 |
| DHEA-Sulfate | 247.8 | | ug/dL | 138.5 - 475.2 | 01 |
| TSH | 1.710 | | uIU/mL | 0.450 - 4.500 | 01 |
| Prostate-Specific Ag, Serum | | | | | |
| Prostate Specific Ag, Serum | 1.0 | | ng/mL | 0.0 - 4.0 | 01 |

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| TESTS | RESULT | FLAG | UNITS | REFERENCE INTERVAL | LAB |
|--|--------|--|--------|----------------------------|-----|
| Roche ECLIA methodology. According to the American Urological Association, Serum PSA should decrease and remain at undetectable levels after radical prostatectomy. The AUA defines biochemical recurrence as an initial PSA value 0.2 ng/mL or greater followed by a subsequent confirmatory PSA value 0.2 ng/mL or greater. Values obtained with different assay methods or kits cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease. | | | | | |
| Estradiol, Sensitive | 48.2 | High | pg/mL | 8.0 - 35.0 | 02 |
| This test was developed and its performance characteristics determined by LabCorp. It has not been cleared by the Food and Drug Administration. Methodology: Liquid chromatography tandem mass spectrometry (LC/MS/MS) | | | | | |
| Sex Horm Binding Glob, Serum | 25.4 | | nmol/L | 16.5 - 55.9 | 01 |
| Cardiovascular Report | | | | | |
| Interpretation | Note | | | | 03 |
| Supplement report is available. | | | | | |
| PDF Image | . | | | | 03 |
| 01 | TA | LabCorp Tampa 5610 W LaSalle Street, Tampa, FL 33607-1770 | | Dir: Sean Farrier, MD | |
| 02 | BN | LabCorp Burlington 1447 York Court, Burlington, NC 27215-3361 | | Dir: William F Hancock, MD | |
| 03 | LITIL | Litholink Corporation 2250 West Campbell Park Drive, Chicago, IL 60612-3502 | | Dir: Mitchell Laks, PhD | |

For inquiries, the physician may contact **Branch: 800-877-5227 Lab: 800-877-5227**

Accessions: 05121609490

DISCLAIMER: These assessments and treatment suggestions are provided as a convenience in support of the physician-patient relationship and are not intended to replace the physician's clinical judgment. They are derived from the national guidelines in addition to other evidence and expert opinion. The clinician should consider this information within the context of clinical opinion and the individual patient.

SEE GUIDANCE FOR CARDIOVASCULAR REPORT: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002. NIH publication 02-5215); Brunzell et al. Diabetes Care 2008; 31(4):811-82; Contois et al. Clin Chem 2009; 55(3):407-419; Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2014;129(suppl 2):S1-S45.

Note: Please refer to your LabCorp Report for all results as well as any test-specific and specimen-specific comments.

Laboratory Director's Notes

Laboratory test values flagged with an asterisk (*) within this report refer to the following commentary from our physicians and quality assurance staff.

| COLLECTION DATE | ITEM | RELATED NOTES |
|-----------------|----------------------|---|
| 02/20/2016 | Total Chol:HDL Ratio | T. Chol/HDL Ratio Men Women 1/2 Avg.Risk 3.4 3.3 Avg.Risk 5.0 4.4 2X Avg.Risk 9.6 7.1 3X Avg.Risk 23.4 11.0 |

Mitchell S. Laks, PhD - Laboratory Director

Current Laboratory Results

Blood Draw Date: 02/20/2016 Date Received: 02/20/2016 Date Completed: 02/21/2016 Fasting: YES

Comp. Metabolic Panel (14)

| ANALYTE | REF. INTERVAL | LOW | HIGH | RESULT |
|------------------------------|---------------|-----|------|--------|
| Glucose mg/dL | 65-99 | | | 104 H |
| BUN mg/dL | 6-20 | | | 17 |
| Creatinine mg/dL | 0.76-1.27 | | | 1.01 |
| Sodium mmol/L | 134-144 | | | 140 |
| Potassium mmol/L | 3.5-5.2 | | | 4.4 |
| Chloride mmol/L | 97-108 | | | 97 |
| Carbon Dioxide mmol/L | 18-29 | | | 25 |
| Calcium mg/dL | 8.7-10.2 | | | 9.7 |
| Protein, Total, Serum g/dL | 6.0-8.5 | | | 6.8 |
| Albumin g/dL | 3.5-5.5 | | | 4.7 |
| Globulin, Total g/dL | 1.5-4.5 | | | 2.1 |
| A/G Ratio | 1.1-2.5 | | | 2.2 |
| Bilirubin, Total mg/dL | 0.0-1.2 | | | 0.6 |
| Alkaline Phosphatase, S IU/L | 39-117 | | | 53 |
| AST IU/L | 0-40 | | | 21 |
| ALT IU/L | 0-44 | | | 18 |
| BUN: Creatinine Ratio | 8-19 | | | 17 |
| Anion Gap mmol/L | 8 - 14 | | | 18 H |
| estimated GFR mL/min/1.73mE2 | > 59 | | | 99 |

Albumin testing performed on the Roche Modular using the ALB PLUS assay.

Lipid Panel with Chol/HDL Ratio

| ANALYTE | REF. INTERVAL | LOW | HIGH | RESULT |
|----------------------------------|---------------|-----|------|--------|
| Total Cholesterol mg/dL | 100-199 | | | 142 |
| Triglyceride mg/dL | 0-149 | | | 68 |
| HDL-C mg/dL | >39 | | | 64 |
| VLDL mg/dL | 5-40 | | | 14 |
| LDL(calc) mg/dL | 0-99 | | | 64 |
| non-HDL cholesterol mg/dL | 0 - 129 | | | 78 |
| Total Chol:HDL Ratio ratio units | 0.0-5.0 | | | * 2.2 |

Legend for Abnormal Flags:

L - Below Low Normal
H - Above High Normal

LL - Alert Low
HH - Alert High

< - Panic Low
> - Panic High

A - Abnormal (applies to non-numeric results)
AA - Critical Abnormal (applies to non-numeric results)

TSH

| ANALYTE | REF. INTERVAL | LOW | HIGH | RESULT |
|------------|---------------|-----|------|--------|
| TSH uIU/mL | 0.450-4.500 | | | 1.710 |

Cardiovascular Report

Patient Assessment

Current available clinical information suggests the patient's risk is at least LOW. If the patient has two or more major risk factors, the risk category is intermediate. If the patient has CHD or a CHD risk equivalent, the risk category is high. If patient does not have CHD or a CHD risk equivalent, consider use of the Pooled Cohort Equations to estimate 10-year CVD risk, as individuals with greater than 7.5% risk may warrant more intensive therapy. The calculator can be found at: <http://tools.cardiosource.org/ASCVD-Risk-Estimator/>

Insulin resistance, obesity, excessive alcohol use, smoking, nephrotic syndrome, liver disease, and certain medications can cause secondary dyslipidemia. Consider evaluation if clinically indicated.

Therapeutic lifestyle changes are always valuable to achieve optimal blood lipid status (diet, exercise, weight management).

Lipid Management

Select one patient risk category based upon medical history and clinical judgment. Additional risk factors such as personal or family history of premature CHD, smoking, and hypertension modify a patient's goals of therapy. In CVD prevention, the intensity of therapy should be adjusted to the level of patient risk. MODERATE intensity statin therapy generally results in an average LDL-C reduction of 30% to less than 50% from the untreated baseline. Examples include (daily doses): atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg. HIGH intensity statin therapy generally results in an average LDL-C reduction of 50% or more from the untreated baseline. Examples include (daily doses): atorvastatin 40-80 mg and rosuvastatin 20 mg.

▽ = PATIENT'S RESULT

ANALYTE / RESULT

LDL-C
64 mg/dL

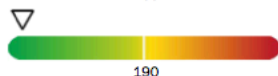
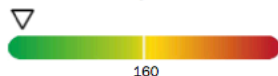
non-HDL
78 mg/dL

**Lipid
Assessment**

**Treatment
Suggestions**

Patient Risk Category (select one)

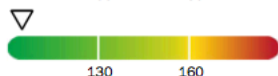
LOW



LDL-C is optimal, was 67 and now is 64 mg/dL. Non-HDL Cholesterol is optimal, was 75 and now is 78 mg/dL.

Considerations for use of statin therapy include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated lifetime CVD risk.

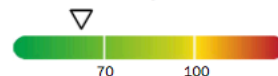
INTERMEDIATE



LDL-C is optimal, was 67 and now is 64 mg/dL. Non-HDL Cholesterol is optimal, was 75 and now is 78 mg/dL.

Consider measurement of LDL particle number or Apo B to adjudicate need for further LDL lowering therapy. Factors that may influence statin use include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated lifetime CVD risk. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant) or niacin.

HIGH



LDL-C is optimal, was 67 and now is 64 mg/dL. Non-HDL Cholesterol is optimal, was 75 and now is 78 mg/dL.

Continue statin if in use. Consider measurement of LDL particle number or Apo B to adjudicate need for further LDL lowering therapy. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant) or niacin.

Patient Results Summary

Cholesterol comes in different forms and has varying effects on your heart health. Some cholesterol is “good” and not known to cause disease, this is HDL. The rest of cholesterol causes disease by clogging your arteries, this is non-HDL. LDL cholesterol is the largest component of the non-HDL cholesterol. Lowering your levels of “bad” cholesterol will lower your risk for disease.

- **LDL cholesterol (LDL-C)** is the largest component of the non-HDL cholesterol (“bad” cholesterol).
- **non-HDL** is composed of many different types of cholesterol (not just LDL-C) and high levels cause disease.

The level to which your LDL must be lowered depends on the risk for developing heart disease or having a heart attack. The higher your risk for heart disease, the lower your LDL goal.

Contributing Risk Factors For Heart Disease

- | | |
|--|---|
| <input type="checkbox"/> Heart and/or vascular disease | <input type="checkbox"/> Cigarette (tobacco) smoking |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low HDL (men less than 40 mg/dL, women less than 50 mg/dL) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Family history of early onset heart disease |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Man over 45 years or woman over 55 years |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Familial Hypercholesterolemia |

Your Heart Disease Risk Category

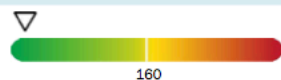
Selected by your physician based upon your risk factors and clinical judgement.

Test /
Your Results

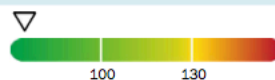
LDL-C
64 mg/dL

non-HDL
78 mg/dL

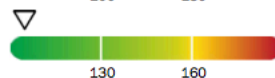
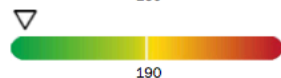
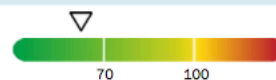
☐ Low



☐ Intermediate



☐ High



▽ = Your Result: Left (Green) = Optimal, Center = Acceptable, Right (Red) = High Risk

Your Care Plan (as selected by your physician)

- | | |
|---|---|
| <input type="checkbox"/> Change your diet: limit saturated / trans fats and cholesterol, increase fiber | <input type="checkbox"/> Control any other medical conditions: such as diabetes, high blood pressure |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Visit your doctor as scheduled and obtain all follow-up tests/treatments recommended |
| <input type="checkbox"/> Lose weight | <input type="checkbox"/> Take all of your medications your doctor(s) have prescribed |
| <input type="checkbox"/> | <input type="checkbox"/> |

DISCLAIMER: You should discuss this information with your physician. Litholink does not have a doctor-patient relationship with you, nor does it have access to a complete medical history or a physical examination that would be necessary for a complete diagnosis and comprehensive treatment plan. Neither you nor your physician should rely solely on this guidance. REFERENCES: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002. NIH publication 02-5215); National Heart, Lung, and Blood Institute's Your Guide to Lowering Your Cholesterol with TLC (2005. NIH publication 06-5235); Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013; 00:000-000.