PRECISION POINT DIAGNOSTICS

Final Report

Patient Information

Name: Mock, Comprehensive
DOB : 01/01/1990
Gender: Female
Phone Number: 6787366374
Ethnicity: Not Specified

Accession #: B233170003
Sample Type : Whole Blood,Serum,
Collected: 11/13/2023 10:47:00 CST
Received:11/13/2023 10:50:51 CST
Result Date:

Facility Information

Facility Name: Precision Point Diagnostics
Provider Name :TMIT Physician
Address: 9 Dunwoody Park, Dunwoody, GA, 30338
Lab Director: Michael Heck, PhD
CLIA #: 1D2251528

MRN:
Comments:

Detailed Results Summary by Panel

COMPLETE METABOLIC PANEL

TEST	RESULT	UNITS	Flag	Reference
Lactate Dehydrogenase (LDH)	145	U/L		135-225
Sodium (Na)	140	mEq/L		136-144
A/G	1.51613			1.5-2.5
Alanine Aminotransferase (ALT)	38	U/L	High	4-36

High ALT is associated with hepatocellular disease (moderate to high increase), alcoholic cirrhosis (mild increase), metastatic liver tumor (mild increase), obstructive jaundice or biliary obstruction (mild increase), cholecystitis; viral, infectious, or toxic hepatitis (30–50 times normal); infectious mononucleosis, pancreatitis (mild increase), MI, heart failure, polymyositis, severe burns, trauma to striated muscle, and severe shock.

Albumin (ALB)	4.7	g/dL		3.5-5.5
Alkaline Phosphatase (ALP)	150	IU/L	High	37-147

Elevated levels of ALP are associated with liver disease (correlated with abnormal liver function tests), and occur in the following conditions: obstructive jaundice (gallstones obstructing major biliary ducts; accompanying elevated bilirubin), space-occupying lesions of the liver such as cancer (hepatic carcinoma) and malignancy with liver metastasis, hepatocellular cirrhosis, biliary cirrhosis, intrahepatic and extrahepatic cholestasis, hepatitis, infectious mononucleosis, cytomegalovirus, diabetes (causes increased synthesis), diabetic hepatic lipidosis, chronic alcohol ingestion, Gilbert syndrome (hyperbilirubinemia), and bone diseases. In bone diseases, elevated ALP levels occur in the following conditions: Paget disease (osteitis deformans; levels 10– 25 times normal), metastatic bone tumor, osteogenic sarcoma, osteomalacia (elevated levels help differentiate between osteomalacia and osteoporosis, in which there is no elevation), rickets, and healing factors (osteogenesis imperfecta). Other diseases involving elevated ALP levels include the following: Hyperparathyroidism (accompanied by hypercalcemia), hyperthyroidism, pulmonary and MIs, Hodgkin's disease, cancer of the lung or pancreas, ulcerative colitis, peptic ulcer, sarcoidosis, perforation of the bowel (acute infarction), amyloidosis, CKD, heart failure, and hyperphosphataemia (primary and secondary).

Anion	11.5	mEq/L	High	3-11

A positive value (higher than + 2 mEq/ L or + 2 mmol/ L) reflects a nonvolatile acid deficit or true base excess. An AG occurs with acidosis that is caused by excess metabolic acids and excess serum chloride levels. If there is no change in sodium content, anions such as phosphates, sulfates, and organic acids increase the AG because they replace bicarbonate. Increased AG is associated with an increase in metabolic acid when there is excessive production of metabolic acids, as in alcoholic ketoacidosis, diabetic ketoacidosis, fasting and starvation, ketogenic diets, lactic acidosis, poisoning (by salicylate, ethylene glycol (antifreeze), methanol, or propyl alcohol). Increased AG is also associated with decreased loss of metabolic acids as in acute kidney injury and kidney disease. In the absence of kidney disease or intoxication with drugs or toxins, an increase in AG is assumed to be caused by ketoacidosis or lactate accumulation. AG includes the determination of three gaps of toxicology (influence of drugs and heavy metals): (1) anion = type A lactic acidosis due to tissue hypoxia, (2) osmolar gap, and (3) oxygen saturation gap. A list of drugs and toxic substances that cause increased AG (> 12 mEq/ L or > 12 mmol/ L) include the following: toxins that cause osmolar gap > 10 mOsm from baseline include ethanol, ethylene glycol, glycerol, hypermagnesemia (> 9.5 mEq/ L or > 9.5 mmol/ L), isopropanol (acetone), iodine (questionable), mannitol, methanol, and sorbitol.

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Aspartate Aminotransferase (AST)	15	U/L		8-34
Bicarbonate (CO2)	23.0	mEq/L		22-29
BUN/CRE	20			5-20
Calcium Arsenazo (CALA)	9.2	mg/dL		8.4-10.2
Chloride (Cl)	105	mEq/L		95-111
Creatinine(CRE)	0.7	mg/dL		0.6-1.3
Direct Bilirubin (DBILC)	0.2	mg/dL		0-0.3
eGFR- Non-African American	144.00		High	59-120
eGFR-African American	166.00		High	59-120
Globulin	3.1	g/dL		1.5-4.5
Glucose(GLU)	350	mg/dL	High	70-100

Increased glucose occurs with DM endocrine disorders (thyrotoxicosis, Cushing's syndrome, acromegaly, liver and pancreatic disease, central nervous system disorders (brain injury, stroke), impaired tubular reabsorption, Fanconi syndrome, advanced renal tubular disease, and pregnancy with possible latent diabetes (gestational diabetes). Any changes in blood sugar are reflected in the CSF approximately 1 hour later because of the lag in CSF glucose equilibrium time. This measurement is helpful in determining impaired transport of glucose from plasma to CSF, increased use of glucose in the CNS, and glucose use by leukocytes and microorganisms.

Inorganic Phosphorous(PHOS)	3.8	mg/dL		2.8-4.5
Potassium (K)	4.0	mEq/L		3.7-5
Total Bilirubin (TBILC)	0.9	mg/dL		0.1-1.2
Total Protein (TP)	7.8	g/dL		6.4-8.3
Urea Nitrogen (BUN)	14.0	mg/dL		6-20
Uric Acid(UA)	4.0	mg/dL		2.4-6.1

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COMPREHENSIVE THYROID W/ANTIBODIES

TEST	RESULT	UNITS	Flag	Reference
Thyroid Peroxidase Antibodies (TPOAb)	2.0	IU/mL		0-3
Free Thyroxine (FT4)	0.82	ng/dL	Low	0.9-1.7
Decreased FT 4 levels are associated with the following conditions: primary hypothyroidism, secondary hypothyroidism (pituitary), tertiary hypothyroidism (hypothalamic), and hypothyroidism treated with T3. T4 can be given to increase levels. ~ Lower levels of T4 can contribute to fatigue, hair loss, feeling cold, hormonal imbalance, headaches, constipation, and many other symptoms. T4 can be increased with tyrosine, zinc, Ashwagandha, and thyroid glandulars.				
Free Triiodothyronine (FT3)	2.1	pg/mL	Low	2.3-4.1
Decreased FT 3 values are associated with hypothyroidism (primary and secondary), and the third trimester of pregnancy. ~ Lower levels of T3 can contribute to fatigue, hair loss, feeling cold, hormonal imbalance, headaches, constipation, and many other symptoms. T3 can be increased with tyrosine, zinc, Ashwagandha, and thyroid glandulars.				
Thyroglobulin (Tg2)	31.0	ng/mL		0-32
Thyroid stimulating Hormone (TSH3)	0.5	µIU/mL		0.3-4.2
Total Thyroxine (TotT4)	4.4	µg/dL	Low	4.5-11.7
Low levels of T4 are associated with primary hypothyroidism, secondary hypothyroidism (pituitary), tertiary hypothyroidism (hypothalamic), and hypothyroidism treated with T3. ~ Lower levels of T4 can contribute to fatigue, hair loss, feeling cold, hormonal imbalance, headaches, constipation, hair loss, lack of focus, depression, and many other symptoms. T4 can be increased with tyrosine, zinc, Ashwagandha, and thyroid glandulars.				
Total Triiodothyronine (TotT3)	0.9	ng/mL		0.8-1.7

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CBC-D

TEST	RESULT	UNITS	Flag	Reference
Basophil%	2.0	%		0-3
Basophils#	0.2	X 10^3/µL		0-0.3
Eosinophils#	0.3	X 10^3/µL		0-0.4
Eosinophils%	3.0	%		1-4
Hematocrit	35.0	%		34.7-48
Hemoglobin	12.0	g/dL		11.5-16
IG#	0.0	X 10^3/µL		0-0.1
IG%	0.0	%		0-1
Lymph #	3.0	X 10^3/µL		0.8-4
Lymph%	45.0	%		16-51
MCH	25.0	pg	Low	26-34
MCHC	34.0	g/dL		32-36
MCV	85.0	fL		80-97
Monocytes#	1.0	X 10^3/µL		0-1.2
Monocytes%	10.0	%		0-12
MPV	11.0	fL		6.5-12.4
Neutrophils#	3.0	X 10^3/µL		1.5-8
Neutrophils%	45.0	%		37-80
Platelet	350	X 10^3/µL		140-450
RBC	4.0	X 10^6/µL		3.8-5.7
RDW	14.0	%		10.5-15.4
WBC	8.2	X 10^3/µL		4.2-10.8

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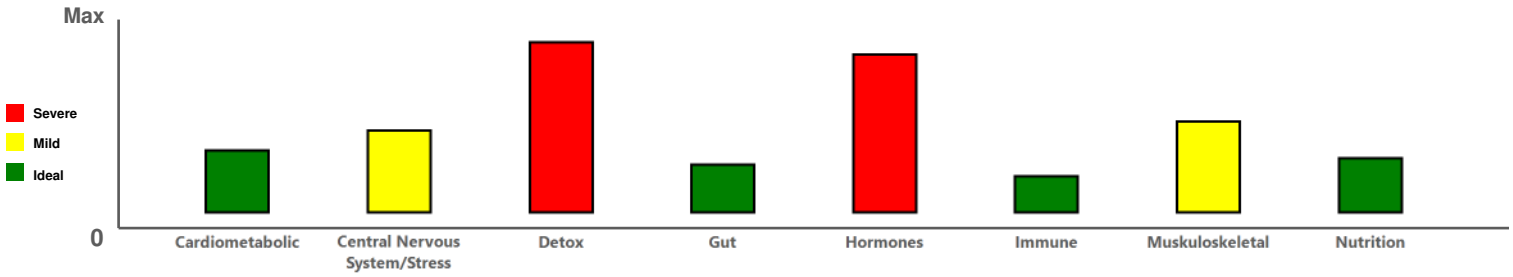
INDIVIDUAL TESTS

TEST	RESULT	UNITS	Flag	Reference
25-Hydroxy Vitamin D (VitdA)	14.0	ng/mL	Low	20-110

Low levels of vitamin D can be associated with the use of anticonvulsants, familial hypophosphatemic rickets, diabetes mellitus, Fanconi syndrome, hypoparathyroidism, renal osteodystrophy, renal tubular acidosis, high phosphate or phytate intake, inadequate diet, inadequate exposure to sunlight (especially in the elderly), liver disease, and malabsorption syndromes.

~ Low levels of vitamin D occur when the tissue is not fully saturated, and therefore serum levels have not gone up. It can also be due to increased utilization secondary to infection, malabsorption, and increased need in cases of autoimmunity. Low normal levels may not be enough to control many symptoms and conditions. If one is taking Vitamin D and levels are low rule out malabsorption.

Magnesium(MG)	2.0	mg/dL		1.7-2.2



END OF REPORT