TEST REPORT

8605 SW Creekside Place
Beaverton, OR 97008
Phone: 503-466-2445 Fax: 503-466-1636

ZRT LABORATORY

 # D2026 05 07 033 SB

Ordering Provider:
Getuwell

Samples Received
05/07/2026

Report Date
05/19/2026

Samples Collected
Saliva - 04/30/26 08:50
Saliva - 04/30/26 13:15
Saliva - 04/30/26 16:20
Saliva - 04/30/26 23:00
Blood Spot - 04/30/26 08:30

Patient Name: Saliva LCMS Hormones 7 with 4-Pt Cortisol + Blood Spot Thyroids, CardioMetabolic + LCMS Vit D

Patient Phone Number:

Gender	Last Menses	Height	Waist
Female	Unspecified	5 ft 5 in	Unspecified
DOB	**Menses Status**	**Weight**	**BMI**
1/1/1975 (51 yrs)	Hysterectomy (ovaries removed)	298 lb	49.6

TEST NAME	RESULTS | 04/30/26	RANGE
Salivary Steroids & Other Analytes (LC-MS/ECLIA)		
Estradiol	3.0 H	0.3-0.9 pg/mL Postmenopausal
Estriol	<0.9	<1.9 pg/mL Postmeno or Premeno-Follicular or Synthetic HRT
Estrone	12.7 H	0.9-3.1 pg/mL Postmeno Premeno-Follicular or Synthetic HRT
Progesterone	<5 L	5-34 pg/mL Postmenopausal
Ratio: Pg/E2 (Saliva LCMS)	N/A	23-196
Testosterone	17	7-22 pg/mL
DHEAS	2.6	0.8-8.0 ng/mL
Cortisol	1.7 L	2.5-6.2 ng/mL (morning)
Cortisol	5.1 H	1.11-2.74 ng/mL (noon)
Cortisol	0.9	0.61-1.33 ng/mL (evening)
Cortisol	0.8 H	0.25-0.64 ng/mL (night)
Blood Spot Steroids & Other Analytes (LC-MS/MS)		
Vitamin D, 25-OH, D2	<4	<4 if not supplementing (< 10 nmol/L)
Vitamin D, 25-OH, D3	25	20-80 ng/ml (50-200 nmol/L)
Vitamin D, 25-OH, Total	25	20-80 ng/ml (50-200 nmol/L)
Blood Spot Thyroids		
TSH	2.00	0.5-3.0 µU/mL
Free T3	3.8	1.9-4.4 pg/mL

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David T. Zava, Ph.D.
Laboratory Director

Alison McAllister, ND.
(Ordering Provider unless otherwise specified on page 1)

TEST NAME	RESULTS | 04/30/26	RANGE
Blood Spot Thyroids		
Free T4	1.4	0.8-1.6 ng/dL
TPOab	17	0-150 IU/mL (70-150 borderline)
Thyroglobulin	4 L	5-51 ng/mL
Total T4	9.1	5-10.6 µg/dL
Blood Spot CardioMetabolic Markers		
Insulin	10.0	1-15 µIU/mL (optimal 2-6)
Hemoglobin A1c	5.5	4-6%
HDL	45	40-60 mg/dL
Triglycerides	119	<150 mg/dL
Cholesterol	211	132-239 mg/dL (200-239 Borderline)
LDL	142	<160 mg/dL (optimal 100-159)
VLDL	24	<30 mg/dL
hsCRP	>11.0 H	<3 mg/L

<dl *= Less than the detectable limit of the lab.* ***N/A*** *= Not applicable; 1 or more values used in this calculation is less than the detectable limit.* ***H*** *= High.* ***L*** *= Low.*

Therapies

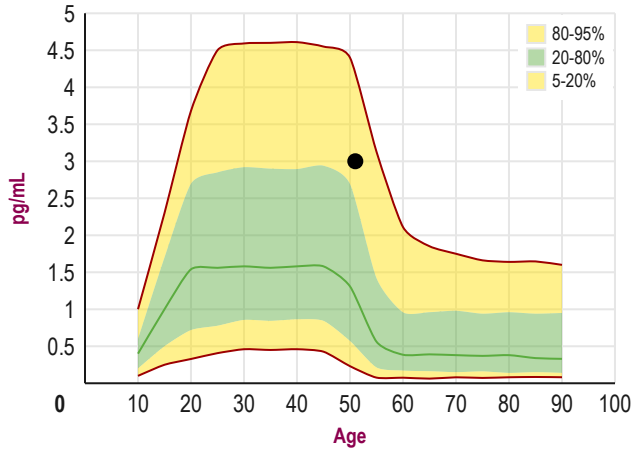
0.15mg oral Levothyroxine (T4) (Pharmaceutical) (23 Hours Last Used)

Graphs

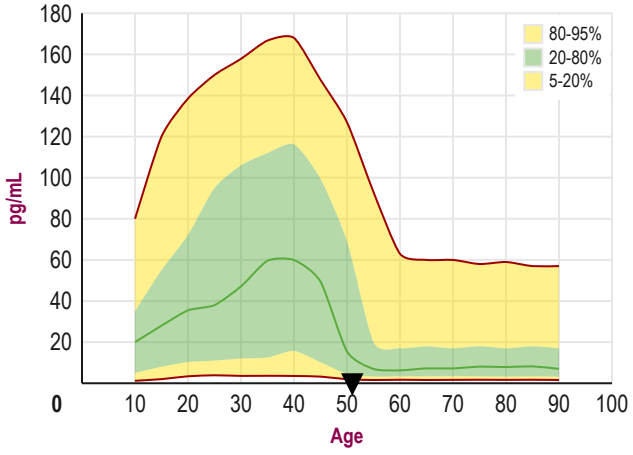
Disclaimer: Graphs below represent averages for healthy individuals not using hormones. Supplementation ranges may be higher. Please see supplementation ranges and lab comments if results are higher or lower than expected.

Average ▼▲ Off Graph

Saliva Estradiol



Saliva Progesterone



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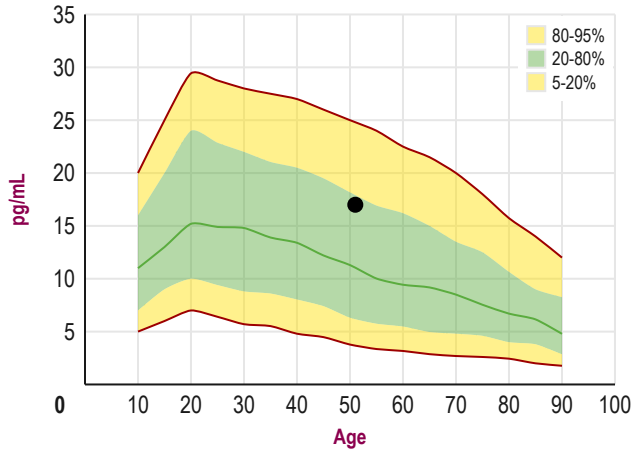
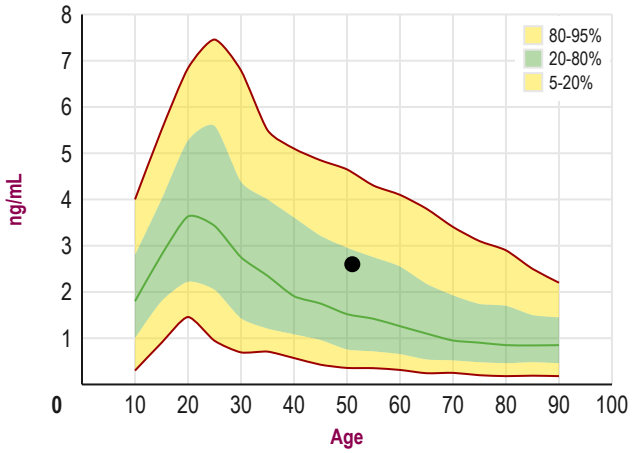
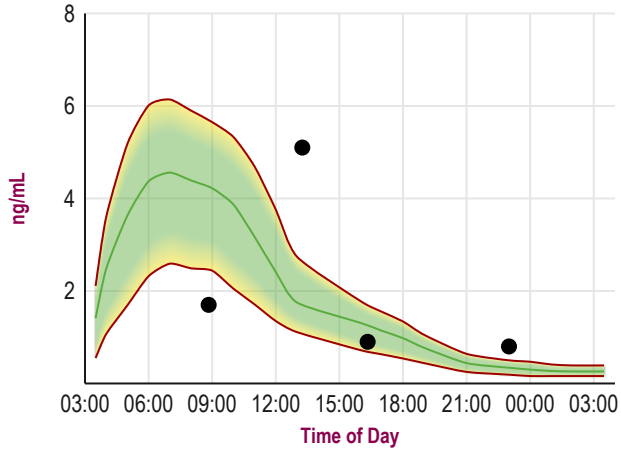
Saliva Testosterone



Saliva DHEAS



Saliva Cortisol



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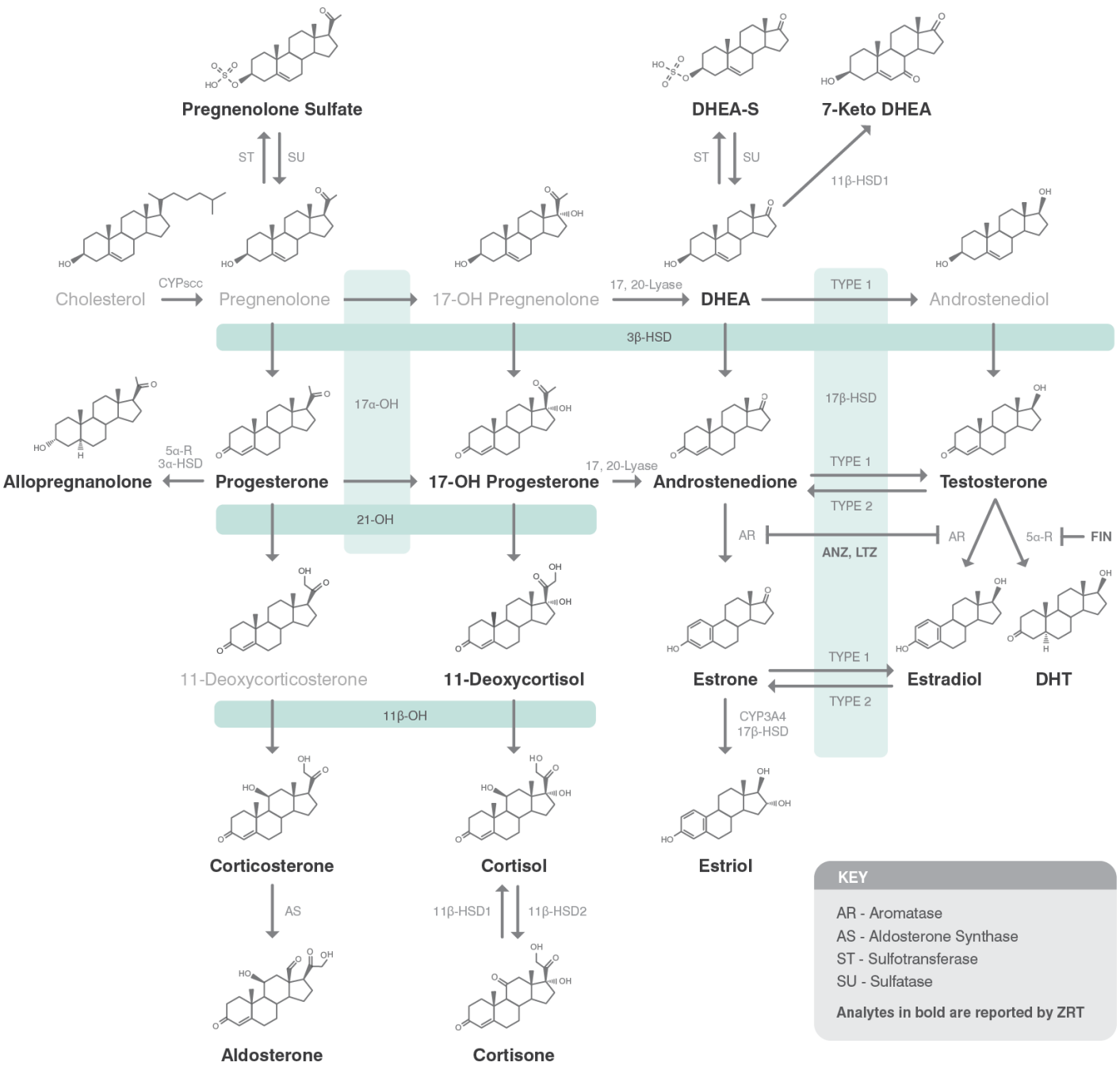
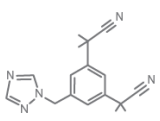
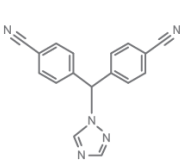
Saliva Steroid Cascade



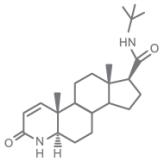
Steroid Synthesis Inhibitors



Anastrozole
ANZ

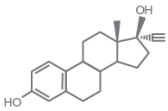


Letrozole
LTZ



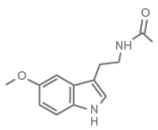
Finasteride
FIN

Synthetic Contraceptive Estrogen



Ethinyl Estradiol

Melatonin



Mel

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TEST REPORT | Patient Report

Disclaimer: Symptom Categories below show percent of symptoms self-reported by the patient compared to total available symptoms for each category. For detailed information on category breakdowns, go to www.zrtlab.com/patient-symptoms.

SYMPTOM CATEGORIES	RESULTS | 04/30/26
Estrogen / Progesterone Deficiency	18%
Estrogen Dominance / Progesterone Deficiency	24%
Low Androgens (DHEA/Testosterone)	37%
High Androgens (DHEA/Testosterone)	10%
Low Cortisol	26%
High Cortisol	24%
Hypometabolism	24%
Metabolic Syndrome	58%

SYMPTOM CHECKLIST	MILD	MODERATE	SEVERE
Aches and Pains	■		
Acne	■		
ADD/ADHD	■		
Addictive Behaviors	■		
Allergies	■		
Anxious	■		
Autism Spectrum Disorder	■		
Bleeding Changes	■		
Blood Pressure High	■	■	■
Blood Pressure Low	■		
Blood Sugar Low	■		
Body Temperature Cold	■		
Bone Loss	■		
Breast Cancer	■		
Breasts - Fibrocystic	■		
Breasts - Tender	■		
Chemical Sensitivity	■		
Cholesterol High	■		
Constipation	■		
Depressed	■		
Developmental Delays	■		
Eating Disorders	■		
Fatigue - Evening	■	■	
Fatigue - Morning	■	■	
Fibromyalgia	■		
Foggy Thinking	■		
Goiter	■		
Hair - Dry or Brittle	■		
Hair - Increased Facial or Body	■		
Hair - Scalp Loss	■		
Headaches	■		
Hearing Loss	■		
Heart Palpitations	■		
Hoarseness	■		
Hot Flashes	■		
Incontinence	■		
Infertility	■		
Irritable	■		
Libido Decreased	■	■	■
Mania	■		

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Lab Comments

ESTROGENS: ESTRADIOL, ESTRONE, ESTRONE

Estradiol (E2) and its inert metabolite estrone (E1) are higher than reference ranges for a perimenopausal woman either producing high levels of endogenous estrogens or having recently used estradiol therapy (none indicated). Estriol (E3) is much lower than E2 and E1, but within/near range for a premenopausal or postmenopausal woman. E3 plays very little role in estrogen physiology and the bioavailable (salivary) reference range levels for E3 generally run low relative to estrone and estradiol.
The ratio of progesterone to estradiol is lower than optimal (100-300), which is common in women approaching menopause in their 40's and 50's (perimenopause). As E2 and E1 fluctuate erratically during perimenopause this triggers symptoms of both estrogen excess (dominance) and deficiency. Progesterone therapy helps balance the excess estrogen by increasing its clearance and down-regulating cellular estrogen receptors to suppress further estrogen stimulation.
Physiological levels of estradiol are necessary for optimal functions of the heart, brain, and reproductive systems throughout life. Following perimenopause ovarian estrogen synthesis ceases and circulating levels of E2 and E1 drop precipitously, resulting in symptoms and conditions of estrogen deficiency. Progesterone therapy may no longer be helpful, especially if used at doses that effectively controlled excess and fluctuating levels of much higher estrogens that occurred at perimenopause. Once estrogen drops to low menopausal levels symptoms and conditions (e.g. hot flashes, night sweats, vaginal dryness, bone loss, weight gain, etc.) should be treated with physiological levels of estradiol and progesterone.

PROGESTERONE is lower than the range expected for a woman not cycling and/or ovulating. Low progesterone may contribute to symptoms of both estrogen dominance symptoms (e.g., mood swings, fibrocystic breast changes and breast tenderness, water retention, and weight gain) and estrogen deficiency (e.g., hot flashes, night sweats). If any of these symptoms of estrogen imbalance are problematic it would be worthwhile to consider supplementation with bio-identical progesterone.

TESTOSTERONE is within normal range but symptoms of androgen deficiency persist. This may be due to poor tissue response to the testosterone or other hormonal imbalances with symptom profiles similar to low androgens (e.g. low thyroid or low cortisol). Testosterone is an anabolic hormone essential for creating energy, maintaining optimal brain function (memory), regulating the immune system, and building and maintaining the integrity of structural tissues such as skin, muscles, and bone.

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DHEAS is within expected reference range for an adult. DHEAS is highest during the late teens (often slightly higher than range) to early twenties and drops steadily with age to the lower end of the range by age 70-80. DHEAS is an important precursor to downstream estrogens (estradiol, estrone) and androgens (androstenedione, testosterone, DHT). If DHEAS is within low-normal range and androgens are low consider DHEA therapy. Oral DHEA therapy at 5-25 mg dosing raises DHEAS. DHEA therapy may also raise the level of testosterone slightly in women but less so in men. Topical DHEA therapy raises DHEA, but has much less effect on DHEAS.

CORTISOL (4x diurnal immunoassay) is low in the morning, high at noon, normal in the evening and high again at night. This erratic production of cortisol suggests adrenal gland dysfunction which may be caused by excessive stressors or poor blood sugar regulation. Under normal conditions adrenal gland synthesis of cortisol is highest in the morning and drops steadily throughout the day to the lowest level at night. If symptoms indicate metabolic syndrome it is worth evaluating cardioimetabolic markers to determine clinical course of action. Adequate sleep, gentle exercise, naps, meditation, proper diet (adequate protein), natural progesterone, adrenal extracts, herbs, and nutritional supplements (vitamins C and B5) are some of the natural ways to help support adrenal function (consult with a health care provider for proper types and dosing). For additional information about strategies for supporting adrenal health and reducing stress(ors), the following books are worth reading: "Adrenal Fatigue", by James L. Wilson, N.D., D.C., Ph.D.; "The Cortisol Connection", by Shawn Talbott, Ph.D.; "The End of Stress As We Know It" by Bruce McEwen; "Awakening Athena" by Kenna Stephenson, MD.

Vitamin D is lower than considered sufficient. Vitamin D levels are considered insufficient between 20-30 ng/ml and sufficient between 30-80 ng/ml. While optimal levels are still being researched, the Endocrine society recommends keeping levels above >30 ng/ml. Other researchers have suggested that vitamin D levels are optimal between 50-80 ng/ml.

Vitamin D deficiency has been closely associated with a wide range of conditions and diseases, which include cardiovascular disease, stroke, osteoporosis, osteomalacia, cancer, and autoimmune diseases such as multiple sclerosis, rheumatoid arthritis, and diabetes (types 1 and 2) (for review see: Holick MF. NEJM 357: 266-281, 2007). Lack of adequate sunlight resulting from geographical location (northern climates), excessive clothing, working indoors during daylight hours, purposely avoiding sunlight with clothing and sunscreens, and aging of the skin contribute to low vitamin D levels. Vitamin D3 may be increased by eating foods high in D3 (fish), exposing the skin to sunshine without sunscreen during mid-day for 15-20min (latitudes below Boston, MA), use of a UVB light, and/or supplementation with Vitamin D3.

TSH is within normal range; however, this does not exclude the possibility of a functional thyroid deficiency if symptoms of thyroid deficiency are problematic.

Free T3 is within normal range with thyroid therapy.

Free T4 is within normal range. Minimal or no symptoms are reported. Please evaluate the TSH as T4 levels will remain within normal range despite high TSH levels.

Thyroid peroxidase (TPO) antibodies are low indicating that Hashimoto's autoimmune thyroiditis is unlikely.

Thyroglobulin is very low. Assuming that the thyroid gland has not been removed and that thyroglobulin antibodies are not present, thyroglobulin levels in blood are a good marker of an individual's average iodine nutritional status over several days to weeks. In an individual with a normal thyroid gland who has received adequate iodine nutrition the thyroglobulin levels are expected to range from about 4-10 ng/ml. Higher levels are associated with inadequate iodine nutrition. When thyroglobulin levels are very low < 3 ng/ml, as seen in this test report, it often indicates: 1) the thyroid gland has been removed; 2) very little thyroglobulin is being synthesized by the thyroid gland, or 3) that anti-thyroglobulin antibodies are present and are interfering with the thyroglobulin assay. When thyroid peroxidase (TPO) antibodies are present there is a very high likelihood (50%) that antibodies to thyroglobulin are also present. Although TPO antibodies are not positive it would be worthwhile to test for anti-thyroglobulin antibodies with a serum test.

Total T4 is within observed range with thyroid therapy.

INSULIN (fasting) is within normal range, but higher than the optimal range of 2-6, suggesting an evolving insulin resistance. Insulin resistance predisposes to significantly increased lifetime risk for developing more serious health conditions such as metabolic syndrome (high blood pressure, excessive weight gain in the waist, elevated blood lipids), diabetes, and cardiovascular disease. Stress reduction, exercise, proper diet (reducing consumption of excessive carbohydrates), and balancing hormones within normal physiological ranges are important for prevention of insulin resistance/metabolic syndrome and long term risks to health.

Hemoglobin A1c (HbA1c) is higher than optimal and suggests and increased risk of developing diabetes. HbA1c is a measure of red blood cell hemoglobin glycation and reflects the average blood glucose for the previous 3 months. The American Diabetic Association recommends the following HbA1c levels: normal <5.7%, prediabetes 5.7%-6.4%, and diabetic >6.5%. People with diabetes have higher HbA1c values because their bodies have difficulty managing their blood sugar levels (hyperglycemia). With persistently higher levels of HbA1c, there is increased risk of developing problems such as eye disease, kidney disease, nerve damage, heart disease, and stroke.
Therapeutic considerations: Decreasing simple carbohydrates, increasing exercise, and optimizing BMI. Even small changes like a 5 min walk after meals can have profound changes in blood sugar control. Supplements like chromium, gymnema, and fiber may be helpful.

HDL cholesterol is within the ranges most health experts consider as low risk for cardiovascular disease. However, HDL-cholesterol should be evaluated in parallel with LDL and triglycerides, which also are risk factors.

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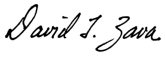
Triglycerides are within normal range, suggesting that insulin resistance/metabolic syndrome is unlikely. Triglycerides are a type of fat in the bloodstream that is taken up by tissues and used as a primary energy source. Triglycerides are derived from fats consumed in food and synthesized in the body from carbohydrates (sugars). Triglycerides are stored by tissues and released into the bloodstream in response to hormonal signals. Elevated triglycerides (hypertriglyceridemia) above 200 mg/dL indicate insulin resistance/metabolic syndrome and is associated with increased risk for heart disease and stroke.

Cholesterol is within a healthy range considered as low risk for cardiovascular disease (assumes triglycerides and HDL cholesterol are also within a healthy range). For additional information see http://en.wikipedia.org/wiki/Cholesterol

High Sensitivity C-Reactive Protein (hs-CRP) is very elevated (> 10 mg/L). Very high levels of hs-CRP are also seen in individuals who have acute inflammation not related to cardiovascular risk. The American Heart Association and the Centers for Disease Control recommend that in individuals with markedly elevated hs-CRP levels (>10 mg/L), other types of inflammation should be considered to exclude noncardiovascular causes. Elevated hs-CRP is a marker of inflammation and contributor to pro-inflammatory and pro-thrombotic elements of cardiovascular disease risk. Elevated hs-CRP is associated with increased risk of future heart attacks, ischemic stroke and peripheral arterial disease. Individuals with elevated hs-CRP are usually insulin resistant, which increases risk for the development of diabetes. Lifestyle changes such as exercise, weight loss, and smoking cessation help lower hs-CRP.



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