

**PATIENT: Sample Report**TEST REF: **TST-##-####**TEST NUMBER: #####  
PATIENT NUMBER: #####  
GENDER: Female  
AGE: 41  
DATE OF BIRTH: dd-mm-yyyyCOLLECTED: dd/mm/yyyy  
RECEIVED: dd/mm/yyyy  
TESTED: dd/mm/yyyyPRACTITIONER: **Nordic Laboratories**  
ADDRESS:**TEST NAME: Fertility ProFile (Saliva: Cx4) (Blood Spot: E2, Pg, T, DS, SHBG, TSH, FT3, FT4, TPOab, FSH, LH)**

Test Name	Result	Range
<b>Salivary Steroids</b>		
Cortisol	<b>9.3</b>	3.7-9.5 ng/mL (morning)
Cortisol	<b>1.7</b>	1.2-3.0 ng/mL (noon)
Cortisol	<b>0.7</b>	0.6-1.9 ng/mL (evening)
Cortisol	<b>0.4</b>	0.4-1.0 ng/mL (night)
<b>Blood Spot Steroids</b>		
Estradiol	<b>29</b>	L 43-180 pg/mL Premeno-luteal or ERT
Progesterone	<b>0.4</b>	L 3.3-22.5 ng/mL Premeno-luteal or PgRT
Ratio: Pg/E2	<b>14</b>	L Pg/E2 (bloodspot-optimal 100-500)
Testosterone	<b>29</b>	20-130 ng/dL Premeno-luteal or TRT
SHBG	<b>84</b>	15-120 nmol/L
DHEAS	<b>74</b>	40-290 µg/dL
<b>Blood Spot</b>		
LH	<b>7.7</b>	0.5-12.8 U/L Premenopausal-luteal
FSH	<b>8.8</b>	H 0.6-8.0 U/L Premenopausal-luteal
<b>Blood Spot Thyroids</b>		
Free T4*	<b>0.9</b>	0.7-2.5 ng/dL
Free T3	<b>2.6</b>	2.4-4.2 pg/mL
TSH	<b>3.3</b>	H 0.5-3.0 µU/mL
TPOab*	<b>18</b>	0-150 IU/mL (70-150 borderline)

&lt;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

\*For research purposes only.

**Therapies**

Turmeric; oral 5-HTP (5-Hydroxytryptophan) (OTC) (1 Days Last Used)

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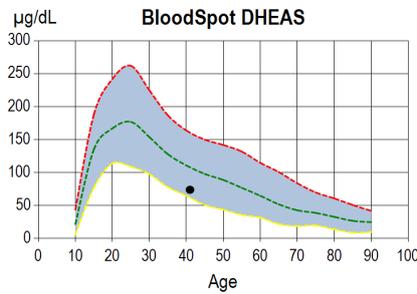
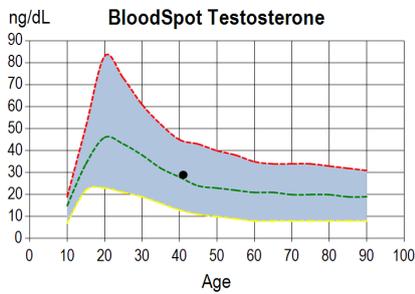
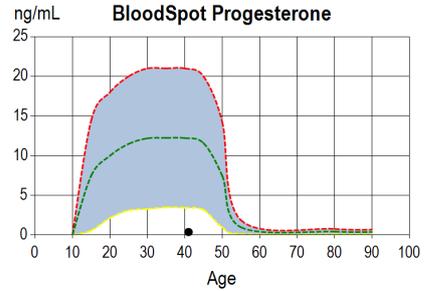
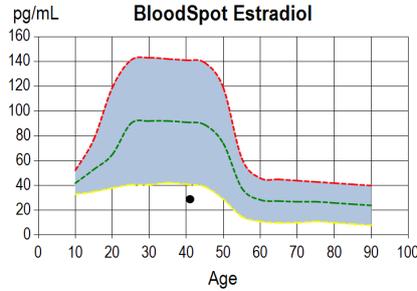
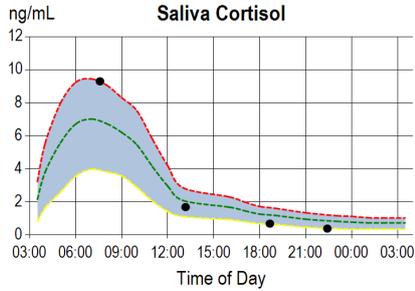
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*Disclaimer: Graphs below represent hormone levels in testers not using hormone supplementation and are provided for informational purposes only. Please see comments for additional information if results are higher or lower than expected. Graph key —High —Avg —Low*





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**Sample Report**

**Lab Comments**

Cortisol is within normal range throughout the day and symptoms of cortisol imbalance are minimal.

Estradiol and progesterone are lower than the premenopausal luteal phase levels as expected and desired. These levels are consistent with day 3 levels.

Testosterone (blood spot) is within the low-normal reference range for a premenopausal woman and symptoms of androgen deficiency are self-reported as minimal. This is also consistent with day 3 levels.

SHBG (Sex Hormone Binding Globulin) is within the high-normal range. SHBG is a protein produced by the liver and released into the bloodstream in response to increasing levels of estrogens. SHBG is a relative index of overall exposure to any form of estrogens (endogenous, pharmaceutical-ERT, xeno-estrogens-pollutants). As the estrogen levels increase there is a proportional increase in SHBG in normal individuals. Excess thyroid medication, or hyperthyroidism, is also associated with elevated SHBG. High insulin (insulin resistance), high androgens, and high glucocorticoids (cortisol) lower SHBG, all of which increase the bioavailability of estradiol and the likelihood of estrogen dominance symptoms. In the circulation, SHBG binds about 37 percent of estradiol, while the remainder binds to albumin; less estrone (16%) and very little estriol (1%) bind to SHBG. Many of the synthetic estrogens, such as ethinyl-estradiol used in oral contraceptives show little binding affinity for SHBG, rendering them more bioavailable and potent than estradiol.

DHEAS is low-normal. Low DHEAS suggests adrenal dysfunction. Low DHEAS may contribute to decreased libido, depression, fatigue, memory lapses, and/or bone loss. DHEA supplementation has been shown in many women to improve the quality and quantity of eggs. See Gleicher & Barad 2011. DHEA supplementation in diminished ovarian reserve. Reprod bio endocrinol.

LH and FSH are in a 1 to 1 ratio as expected.

FSH is slightly higher than expected, but is still considered optimal for fertility. Levels of FSH on day 3 of the menstrual cycle are optimal if less than 9, but levels are considered satisfactory if less than 12. Ideally, two FSH readings should be done with the highest value as being the most accurate. A higher FSH is suggestive of diminishing egg reservoir. It does not determine that fertility is not possible. In fact, a recent study from Europe showed that 6% of pregnant (and hence fertile) patients had an elevated FSH above 12.5 before conceiving. Age, clotting factors and male sperm health are also additional factors that are independent of FSH levels. However, if fertility is desired and more than 6 months have passed with attempting pregnancy, interventions may be beneficial. It may also be beneficial to assess ovarian egg reserve with an Anti-Mullerian Hormone test. It is another way to monitor ovarian egg production. For more information about fertility see [www.resolve.org](http://www.resolve.org)

Free T4 is within normal range but lower than the optimal range of 1-2. Reported symptoms of thyroid deficiency are minimal. If symptoms become more problematic it would be worthwhile to consider thyroid therapy or modification of any hormonal imbalances (eg. high estradiol, low progesterone, low testosterone, high or low cortisol) that might impede optimal thyroid function.

Free T3 is within normal range, but lower than the optimal range of 3-4. The low-normal T3 is NOT associated with a significant number of thyroid deficiency symptoms. If symptoms become more problematic it would be worthwhile to consider thyroid therapy or modification of any hormonal imbalances (eg. high estradiol, low progesterone, low testosterone, high or low cortisol) that might impede optimal thyroid function.

TSH is high. Although most laboratories have a TSH range of 0.35-5.50, new studies are finding that the mean and median values are 1.0-1.5mU/l. TSH levels >3.0 are now considered abnormal due to changes by the endocrinology association - see [www.aace.com](http://www.aace.com) for more information. Some experts believe that TSH should be kept below 2.0 for optimal health. Elevated TSH is often associated with symptoms of hypothyroidism, which include fatigue, decreased stamina, depression, rheumatic pain, sleep disturbances, cold extremities or feeling cold, reduced body temperature, brittle nails, dry coarse hair, hair loss, infertility, low libido, puffy eyes and face, decreased sweating, menorrhagia, and/or constipation. Periodic TSH monitoring is recommended if clinical symptoms of thyroid deficiency persist. T3 results may help guide treatment decisions. Thyroid therapy may be worthwhile considering if T4 and/or T3 are low and symptoms of thyroid deficiency are problematic.

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