Meridian Valley LAB

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Office Hours: 7am-5:30pm PST Monday--Friday

24-Hour Urine Collection and Shipping Instructions

Contamination Warning

For women applying hormone cream/gel on labia and/or vaginally, before collection, thoroughly wash genital area. On the day of urine collection, DO NOT apply hormone cream/gel to the vaginal labia region as contamination can occur. Apply the hormone cream/gel to the rectal mucosa junction on the day of collection. Applying to other areas of the body (arms, legs, etc) may result in reduced absorption. Immediately contact your physician or this lab for questions. Failure to comply with these instructions could result in a contaminated urine sample necessitating a recollection and retest at prevailing lab rates.

Kit Contents:

1 - Instruction Sheet-Questionnaire, & Requisition Form
1 - Urine Collection Cup
1 - Orange Urine Jug (w/ a Boric Acid Tablet)
3 - 50 mL Urine Vials
1 - Ice Pack (*situated inside the lid of Styrofoam container*)
3 - Biohazard Bags
1 - Cardboard Shipping Box
1 - Styrofoam Container
1 - UPS Next Day Air Pack (US & Canada only)
1 - UPS Next Day Shipping Label (US & Canada only)

IMPORTANT INFORMATION - read this before beginning collection

1. If on hormone replacement therapy (estrogens, testosterone, thyroids, etc), consult with prescribing physician as to whether these hormones should be taken during collection. It is generally recommended to continue hormone replacement during collection.
2. Collection should be done on a day with typical level of stress. Do not collect on a day of abnormally high stress.
3. Avoid flax, flaxseed, borage, and primrose supplements a week prior to and during collection.
4. Day 1 of the menstrual cycle is the first day of bleeding. It is recommended that a normally cycling woman collect urine on day 19, 20 or 21 of a 28 day menstrual cycle. If the cycle is longer or shorter than 28 days, add or subtract a corresponding number of days and adjust the collection date. For example, if on a 30 day cycle, simply add two days to the collection day; in this case it would be days 21, 22, or 23.
5. If postmenopausal, and cyclically administering estrogens and progesterone, do not collect urine until on both estrogens and progesterone for at least 5 days. Postmenopausal women not on hormone replacement or who take hormones continuously may collect urine on any day.
6. Limit fluid intake to 2 liters (68oz), this includes all fluids throughout the 24 hour period. Do not exceed normal intake of caffeine, alcohol, and vitaminC 24 hours before and during urine collection.
7. Avoid contaminating urine collection with blood and/or feces. Should contamination occur, rinse the jug, empty completely, and recollect.
8. If any specimen is missed or spilled during collection time, discard all the urine, rinse the jug, empty completely, and recollect.
9. When no boric acid tablet in the jug, refrigerate the jug for the entire collection time. With the boric acid tablet it can be left at room temp.
10. If more than one jug is needed, another clean plastic container may be used. Do NOT use glass or metal, only plastic and refrigerate the sample. Contact lab for details.

COLLECTION INSTRUCTIONS

Send specimens Monday through Thursday only.

1. PLACE THE STYROFOAM LID, WHICH CONTAINS THE ICE PACK, INTO FREEZER BEFORE COLLECTION IF SHIPPING TO LAB.
2. Begin urine collection at any time. To begin, empty bladder completely. Do not collect this urine. Record this time (from the voided urine) as the starting time.
3. For the next 24 hours, collect ALL urine – day and night. At exactly the same time the next day, urinate a final time into the container. *For example:* if the collection began at 10am Monday (from when urine was voided), it should be completed at exactly 10am Tuesday.
4. At completion of 24 hour collection, record the total volume (exact TV required) by placing the collection jug in an upright position and reading the volume from the scale. Record the volume of the complete collection on the Requisition form and on the vials.
5. Secure lid and invert collection jug. Pour urine into all 3 vials up to the upper 40mL line. Label vials with name, date.
6. Complete Hormone Symptom Questionnaire ON THE REVERSE SIDE, Requisition Form, and payment if required.

SHIPPING INSTRUCTIONS

do not ship the whole jug ever!

1. Place vials in the zippered portion of the biohazard bags, and seal the bag.
2. Place the requisition and questionnaire in the outside pocket of the biohazard bag along with payment if required.
3. Place the bags into the Styrofoam container. Take the lid with the ice pack and place on top of the Styrofoam container. Place the container in the cardboard shipping box.
4. Place the cardboard box in the UPS next day air pack and securely seal.
5. Place the return shipping label with barcode on the outside UPS next day air bag.
6. Call UPS toll free 1-800-742-5877 for pickup or nearest drop location. When calling for UPS pickup, request "air" only. Anything else may result in a patient charge.

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Hormone Symptoms Questionnaire

Access # _____

Last Name: _____ **First Name:** _____

Age: _____ Height: _____ Weight: _____ Blood Pressure: _____

Previous / Current use of Hormones / Medications Please indicate any hormone(s) you have used in the past **2 months** as shown in the example below. Also list other medications or herbal supplements you are taking. (Use back if necessary)

FOR LAB USE ONLY. THIS WILL ONLY BE USED INTERNALLY AND WILL BE DISCUSSED ONLY WITH YOU OR YOUR DOCTOR.

Prescriptive Meds	**(Example)**	1	2	3	4
Medication	**Progesterone**				
Brand Used	**Promentium™**				
Delivery	**Oral**				
Amount (in mg's)	**100 mg**				
Date and time last used	**6/1/01 7:30PM**				
# of times/days, days/month	**1 25**				
How long used	**2 years**				

Other Supplements	**(Example)**				
	DHEA/Pregnenolone				
	Soy / Flaxseed				
	DIM / I3C				

Symptoms Please indicate the symptoms you are experiencing as **0 (none), 1 (mild), 2 (moderate), 3 (severe).** For example if you are moderately stressed you would indicate this by darkening the 2 next to "Stress" : 0 1 **2** 3 Stress

Male Questionnaire

Please Report the symptoms you are currently experiencing

0 1 2 3 Burned Out Feeling	0 1 2 3 Apathy	0 1 2 3 Difficulty Sleeping	0 1 2 3 Increased Forgetfulness
0 1 2 3 Decreased Mental Sharpness	0 1 2 3 Depressed	0 1 2 3 Mental Fatigue	0 1 2 3 Irritable
0 1 2 3 Nervousness	0 1 2 3 Anxious	0 1 2 3 Morning Fatigue	0 1 2 3 Evening Fatigue
0 1 2 3 Decreased Stamina	0 1 2 3 Decreased Muscle Size	0 1 2 3 Sore Muscles	0 1 2 3 Increased Joint Pain
0 1 2 3 Decreased Flexibility	0 1 2 3 Neck Or Back Pain	0 1 2 3 Weight Gain - Breast or Hips	0 1 2 3 Weight Gain - Waist
0 1 2 3 Elevated Triglycerides	0 1 2 3 Sugar Craving	0 1 2 3 Heart Palpitations	0 1 2 3 Dizzy Spells
0 1 2 3 Headaches	0 1 2 3 Ringing In Ears	0 1 2 3 Cold Body Tempurature	0 1 2 3 Allergies
0 1 2 3 Sensivitivity To Chemicals	0 1 2 3 Decreased Erections	0 1 2 3 Decreased Libido	0 1 2 3 Prostate Problems
0 1 2 3 Decreased Urine Flow	0 1 2 3 Increased Urinary Urge	0 1 2 3 Stress	0 1 2 3 Other _____

Female Questionnaire

☐ Regular Cycles ☐ Irregular Cycles ☐ No menstrual Cycles

Hysterectomy: ☐ No ☐ Yes Ovaries Removed: ☐ No ☐ One ☐ Both

Pregnant: ☐ No ☐ Yes Month of Pregnancy _____

Polycystic Ovarian Syndrome ☐ No ☐ Yes

Date of Last Menses _____ For specimen collection: # of days in cycle from day 1 of last menses _____

When was the last time you used hormone based birth control (pills, IUD, etc.) _____ How long were you on it? _____

0 1 2 3 Hot Flashes	0 1 2 3 Bone Loss	0 1 2 3 Water Retention	0 1 2 3 Acne
0 1 2 3 Vaginal Dryness	0 1 2 3 Depressed	0 1 2 3 Tearful	0 1 2 3 Irritable
0 1 2 3 Foggy Thinking	0 1 2 3 Anxious	0 1 2 3 Morning Fatigue	0 1 2 3 Evening Fatigue
0 1 2 3 Aches And Pains	0 1 2 3 Fibromyalgia	0 1 2 3 Sleep Disturbed	0 1 2 3 Nervousness
0 1 2 3 Loss Scalp Hair	0 1 2 3 Elevated Triglycerides	0 1 2 3 Weight Gain - Hips	0 1 2 3 Weight Gain - Waist
0 1 2 3 Tender Breasts	0 1 2 3 Sugar Craving	0 1 2 3 Heart Palpitations	0 1 2 3 Mood Swings
0 1 2 3 Night Sweats	0 1 2 3 Loss of Eyebrows	0 1 2 3 Cold Body Temperature	0 1 2 3 Allergies
0 1 2 3 Headaches	0 1 2 3 Bleeding Changes	0 1 2 3 Decreased Libido	0 1 2 3 Uterine Fibroids
0 1 2 3 Sensitivity To Chemicals	0 1 2 3 Stress	0 1 2 3 Incontinence	0 1 2 3 Fibrocystic Breasts
0 1 2 3 Memory Lapse	0 1 2 3 Increased Facial And Body Hair		0 1 2 3 Other _____