Meridian Valley LAB

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Instructions for:	24-Hour Urine Hormone Test(s)
When to ship:	Monday-Thursday
DO NOT SHIP the day before an observed holiday.	Observed holidays: New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and following Friday, and Christmas Day.
Notes for this test:	Please complete the Hormone Questionnaire included in this test kit and return it with the test specimens. The information you provide is confidential and will be used to assist your health care practitioner in understanding your test results and to help us improve our tests.

Kit Contents:	
1 Requisition form	1 Ice pack
1 Instruction sheet	3 Ziplock bags
1 Hormone questionnaire	3 Biohazard bags
1 Collection cup	1 Styrofoam container
1 Collection jug	1 Cardboard outer box
3 Clear vials	1 UPS Lab Pak
	1 UPS return label

Prior to Collection

Before starting collection, review all of the collection instructions.

- ☐ Place the Styrofoam lid of the kit, which contains the ice pack, into the freezer prior to starting collection. Be sure to keep the ice pack inside the lid when freezing. Not doing so may result in the ice pack expanding so that it will not fit in the lid.
- ☐ Collection should be done on a day that is typical for you. Do not collect on a day of unusually high stress or when frequent collection of urine would be difficult.
- ☐ If using hormones (estrogen, testosterone, thyroid, etc.) ***consult your health care practitioner*** as to whether these hormones should be used during the collection period. It is usually recommended to continue hormone replacement during collection.

What day to collect:

- **Men and post-menopausal women** who are ***not*** taking hormones can collect any day of the month.
- **Women with regular menstrual cycles** should collect on day 19, 20, or 21 of a 28-day menstrual cycle. Day 1 of the menstrual cycle is the first day of bleeding. If your monthly cycle is longer or shorter than 28 days, add or subtract a corresponding number of days and adjust the collection date. For example, if you have a 30 day cycle, add two days and collect on day 21, 22, or 23.
- **Women with irregular menstrual cycles** should consult your health care practitioner about when to collect.
- **Postmenopausal women who are using hormones** should collect when hormones have been in use for at least 5 days in a row.

For 48 hours prior to collection and on the day of collection:

- ☐ If you are using a DHEA or hydrocortisone (cortisol) **cream** in the vaginal area, it **should be applied elsewhere** on the day of collection on the same type of skin. Apply creams to the surface of the anal opening for a similar level of absorption.
- ☐ Do not exceed your usual intake of caffeine, alcohol, and Vitamin C.
- ☐ **Nitrates testing (men):** Avoid foods high in nitrites and nitrates, such as preserved meats (sandwich meats, bacon, ham, etc.) as well as Swiss chard, kale, spinach, celery, and root vegetables. The high nitrate/nitrite content of these foods may alter test results.

Collection Instructions:

- ☐ Begin urine collection at any time. To begin, urinate into the toilet and record the time and date on the Hormone Questionnaire. ***Do not add this first urination to the orange collection jug.***
- ☐ Collect all other urine for the next 24 hours using the enclosed collection cup and add to the orange collection jug.
- ☐ Do not exceed 2 liters (68 ounces) of fluid intake, unless pregnant, nursing, or directed by your health care practitioner. This includes all fluids throughout the 24-hour period.
- ☐ The next day, make a final collection at the same time as you started the test on the previous day. Record this time on the hormone questionnaire.

Frequently Asked Questions:

- What if I miss a collection? What if some of the urine gets spilled?

  If any specimen is missed /spilled during collection time you will need to start over.
- I got my period the night of my 24-hour collection. What should I do?

  If any specimen gets contaminated with blood or feces, you will need to start over.
- If I need to recollect, what should I do with the urine I already collected?

  Discard all the urine, rinse the jug with hot water, empty completely, and recollect.
- Help! I need to recollect, but I don't have another boric acid tablet for the jug. What should I do?

  When there is no boric acid tablet in the jug, refrigerate the jug for the entire 24-hour collection period.
- I am trying to limit my water intake, but I am still going to have more urine than fits in this jug. What should I do?

  If more than one jug is needed, another clean plastic container may be used. Do not use glass or metal. Contact lab for additional information as to how to mix the two samples together.

Proper collection makes a difference in your test results!

*If you have questions about how to collect your urine for this test, watch our collection video at **meridianvalleylab.com***

If you still have questions, please consult your health care practitioner or call us at 855-405-TEST (8378).

This test takes 10-14 business days to process.

Shipping Your Test Back to the Lab:

- ☐ Measure the total volume in jug by placing it in an upright (vertical) position and reading the volume from the scale. Record the total volume on the Hormone Questionnaire and on all three vials.
- ☐ Secure lid and invert collection jug to mix the contents. Pour urine into all 3 vials up to the upper 40mL line. Secure the lids tightly. Make sure labels all have name, date, and total volume of 24-hour urine collection.
- ☐ Place each vial into one of the small (3' x7") Ziplock bags and seal.
- ☐ Place each Ziplock bag with its vial in the zippered portion of a biohazard bag and seal the bag.
- ☐ If you haven't already done so, **please fill out the Hormone Questionnaire now.** This is important for helping us interpret the results for your health care practitioner.
- ☐ Fold the Requisition form and completed Hormone Questionnaire and place in the outside pocket of one of the biohazard bags, along with payment, if required.
- ☐ Place all three bags into the Styrofoam container. Place the lid with the frozen ice pack on top, and place the Styrofoam container into the cardboard shipping box.
- ☐ Place the shipping box in the UPS Lab Pak and seal securely. (Alaska and Hawaii: FedEx)
- ☐ Place the return shipping label with barcode on the outside of the Lab Pak.
- ☐ Ship back to Meridian Valley Lab using the provided courier service:

To schedule a pick-up:	**To find a drop-off location:**
UPS: 1-800-742-5877	UPS: https://www.ups.com/dropoff?loc=en_US
FedEx: 1-800-436-3339 (Alaska & Hawaii)	FedEx: http://www.fedex.com/us/dropbox/

Meridian Valley LAB

For lab use only:

Hormone Questionnaire for 24-Hour Urine Panels

Please fill out **BOTH SIDES** of this questionnaire as completely as possible.
The information you provide is confidential and will be used to help us provide interpretative information to your health care provider and improve our tests.

Last Name: ______________________ **First Name:** ______________________

Age: __________ **Height:** __________ **Weight:** __________ **Blood Pressure:** __________

Collection start: ______________ (date/time)
Collection end : ______________ (date/time)
Total Volume: ______________

Symptoms

Please report the symptoms and conditions you are experiencing using a 0-5 scale:

⓪ None or Never — ① Mild or Infrequent — ② — ③ Moderate or Frequent — ④ — ⑤ Severe or Daily

Please fill in the circle of the number that most closely corresponds to what you are experiencing.

Scale	Symptom	Scale	Symptom	Scale	Symptom
0 1 2 3 4 5	Joint or Muscle Pain	0 1 2 3 4 5	Stress	0 1 2 3 4 5	Sugar cravings
0 1 2 3 4 5	Fibromyalgia	0 1 2 3 4 5	PTSD	0 1 2 3 4 5	Low blood sugar
0 1 2 3 4 5	Headaches	0 1 2 3 4 5	Heart palpitations	0 1 2 3 4 5	High cholesterol
0 1 2 3 4 5	Neck or back pain	0 1 2 3 4 5	Rapid heart beat	0 1 2 3 4 5	Elevated triglycerides
0 1 2 3 4 5	Decreased strength	0 1 2 3 4 5	Slow heart beat	0 1 2 3 4 5	Abdominal weight gain
0 1 2 3 4 5	Numbness in hands or feet	0 1 2 3 4 5	Dizzy spells/fainting	0 1 2 3 4 5	Bone loss
0 1 2 3 4 5	Decreased flexibility	0 1 2 3 4 5	High blood pressure	0 1 2 3 4 5	Allergies
0 1 2 3 4 5	Decreased muscle size	0 1 2 3 4 5	Low blood pressure	0 1 2 3 4 5	Sensitivity to chemicals
0 1 2 3 4 5	Decreased stamina	0 1 2 3 4 5	Ringing in the ears	0 1 2 3 4 5	Decreased libido
0 1 2 3 4 5	Insomnia/disturbed sleep	0 1 2 3 4 5	Hearing loss	0 1 2 3 4 5	Fertility problems
0 1 2 3 4 5	Morning fatigue	0 1 2 3 4 5	Hoarseness	0 1 2 3 4 5	Loss of eyebrows
0 1 2 3 4 5	Evening fatigue	0 1 2 3 4 5	Goiter/Swelling in neck	0 1 2 3 4 5	Loss of scalp hair
0 1 2 3 4 5	Burned out feeling	0 1 2 3 4 5	Water retention	0 1 2 3 4 5	Puffy eyes/face
0 1 2 3 4 5	Apathy/Mental Fatigue	0 1 2 3 4 5	Urinary incontinence	0 1 2 3 4 5	Hair dry or brittle
0 1 2 3 4 5	Depression	0 1 2 3 4 5	Constipation	0 1 2 3 4 5	Nails breaking or brittle
0 1 2 3 4 5	Mood swings/tearfulness	0 1 2 3 4 5	Cold/Heat Intolerance	0 1 2 3 4 5	Thinning skin
0 1 2 3 4 5	Irritability/Anger	0 1 2 3 4 5	Hot flashes	0 1 2 3 4 5	Acne
0 1 2 3 4 5	Nervousness/anxiety	0 1 2 3 4 5	Decreased sweating	0 1 2 3 4 5	Rapid aging
0 1 2 3 4 5	Foggy thinking/ Loss of Concentration	0 1 2 3 4 5	Excessive sweating/ Night sweats	0 1 2 3 4 5	Increased facial and/or body hair
0 1 2 3 4 5	Forgetfulness/ Memory lapse	0 1 2 3 4 5	Insulin resistance or type II diabetes	0 1 2 3 4 5	Other:

Women Only:

Scale	Symptom	Scale	Symptom
0 1 2 3 4 5	Vaginal Dryness	0 1 2 3 4 5	Endometriosis
0 1 2 3 4 5	Painful periods	1 Yes 2 No	History of miscarriage
0 1 2 3 4 5	Heavy periods	1 Yes 2 No	Breast cancer
0 1 2 3 4 5	Bleeding changes	1 Yes 2 No	Ovarian cancer
0 1 2 3 4 5	Weight gain around hips	1 Yes 2 No	Cervical cancer
0 1 2 3 4 5	Breast Tenderness/ Fibrocystic Breasts	1 Yes 2 No	Uterine or endometrial cancer
0 1 2 3 4 5	PMS (Pre-menstrual Syndrome)	0 1 2 3 4 5	(PCOS) Polycystic Ovarian Syndrome
0 1 2 3 4 5	Uterine fibroids	0 1 2 3 4 5	Other ovarian cysts

Menstrual cycles: ① Regular ② Irregular ③ None
How many days, on average, between 1st day of one period to 1st day of next period? __________
Date of last menses: ______________ On what day of your cycle did you collect? __________
(Day 1 is the first day of bleeding.)
Hysterectomy: ① No ② Yes If Yes, were your ovaries removed? ① No ② Both ③ One
Are you currently pregnant? ① No ② Yes Month of pregnancy __________
Are you currently breastfeeding? ① No ② Yes
When was the last time you were on hormone-based birth control? (IUD, pills, etc.) __________
How long did you use hormone-based birth control? __________

Men Only:

Scale	Symptom
0 1 2 3 4 5	Decreased erections
0 1 2 3 4 5	Decreased urine flow
0 1 2 3 4 5	Increased urinary urge
0 1 2 3 4 5	Prostate problems
1 Yes 2 No	Prostate cancer
1 Yes 2 No	Testicular cancer
0 1 2 3 4 5	Breast development

Please turn over to complete the rest of the questionnaire.

Last Name: ______________________ **First Name:** ______________________

Hormone/Medication Use

Please list any hormones or medications you have used in the past 6 months. For "**Delivery Form**" use **Oral** (swallowed), **Sublingual** (under tongue), **Cream/gel** (state where applied), **Injection**, **Pellets**, **Nasal spray**, or other delivery form. Include hormone-based contraceptives. Please include non-hormonal prescription or over-the-counter medications. (Use a second sheet if necessary)

Hormone or Medication	Brand Name	Delivery Form	Dosage (in mg)	Times per day	Days per month	How long used?	Last date/ time used
Estrogens							
Progesterone							
Testosterone							
DHEA							
Pregnenolone							
Melatonin							
Oxytocin							
Thyroid							
Cortisol, Cortef, Hydrocortisone							
Synthetic corticosteroids: Prednisone, Dexamethasone, etc.							
Human growth hormone							
Other Prescriptions:							

Herbs/Supplement Use

Please answer the following questions and then list any additional supplements you are using:

1. Have you taken any of the following B vitamins in the past week?

   ① Vitamin B6 (Pyridoxyl-5-phosphate) ② Vitamin B2 (Riboflavin) ③ Vitamin B3 (Niacin, nicotinamide, niacinamide) ④ Vitamin B Complex

2. Have you engaged in high-intensity, weight-bearing exercise (1 hour or more per day) in the past week? ① Yes ② No

   If yes, please state type of exercise:

3. A serving of meat is about 3 ounces, or about the size of a deck of cards.

   Approximately how many servings of red meat have you had in the past week? ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
   (beef, lamb, buffalo, venison, etc.)

   Approximately how many servings of other meats have you had in the past week? ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
   (pork, chicken, turkey, other fowl, fish or seafood)

4. Are you using 5-HTP or tryptophan supplements ? ① Yes ② No

Supplement Name	Supplement Name	Supplement Name