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**PATIENT CHART -**  
**Boerner, Stephen**  
**2649 tiffon st s**  
**Gulfport FL 33711**  
**O: (215) 530-0545(preferred)**

**DOB: 6/25/1985 AGE: 39 yrs. Acct#: 226**

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## **DEMOGRAPHICS**

NAME: Boerner, Stephen  
PATIENT ID#: 226  
MRN:  
BIRTH DATE: 6/25/1985  
AGE: 39 yrs.  
GENDER: M  
ADDRESS: 2649 tiffon st s  
Gulfport FL 33711  
Home:  
Work:  
Cell: (215) 530-0545  
EMAIL: STEPHENANDMELISSABOERNER@GMAIL.COM  
PROVIDER: BOKHARI,HASSAN,MD  
REFERRING PROVIDER: HASSAN BOKHARI MD

716 SEMINOLE BLVD  
LARGO FL 33770  
(727) 238-3241

## **INSURANCE**

FLORIDA BLUE SHIELD  
PO BOX 1798  
JACKSONVILLE, FL 32231

Policy #: TGM896055110  
Policy Holder: Stephen Boerner

## **ALLERGIES**

Augmentin Current 5/15/2024  
Reaction: Treatment:

## **MEDICAL PROBLEM LIST**

No data on file

## **MEDICATION DETAIL**

Historical:  
SIG: guanfacine 1 mg oral tablet, 30 days, Dispense #30 Tablet, 0 Refills, Directions: Take one tab at bedtime  
5/15/2024 SAVARD,ZAINAB,NP  
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Historical:  
SIG: sertraline 100 mg oral tablet, 30 days, Dispense #30 Tablet, 0 Refills, Directions: Take on tab daily  
5/15/2024 SAVARD,ZAINAB,NP  
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Historical:  
SIG: Trileptal 150 mg oral tablet, 30 days, Dispense #60 Tablet, 0 Refills, Directions: Take one tab twice a day  
5/15/2024 SAVARD,ZAINAB,NP  
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Current:  
SIG: guanfacine 1 mg oral tablet, 30 days, Dispense #30 Tablet, 0 Refills, Directions: Take one tab at bedtime  
5/15/2024 SAVARD,ZAINAB,NP

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DOB: 6/25/1985 AGE: 39 yrs. Acct#: 226

SIG: sertraline 100 mg oral tablet, 30 days, Dispense #30 Tablet, 0 Refills, Directions: Take on tab daily  
5/15/2024 SAVARD,ZAINAB,NP

Current:  
SIG: Trileptal 150 mg oral tablet, 30 days, Dispense #60 Tablet, 0 Refills, Directions: Take one tab twice a day  
5/15/2024 SAVARD,ZAINAB,NP

Current:  
SIG: guanfacine 1 mg oral tablet, 30 days, Dispense #30 Tablet, 3 Refills, Directions: Take one tab at bedtime  
6/12/2024 SAVARD,ZAINAB,NP

Current:  
SIG: hydroxyzine HCl 25 mg oral tablet, 30 days, Dispense #30 Tablet, 3 Refills, Directions: Take one tab at bedtime  
6/12/2024 SAVARD,ZAINAB,NP

Current:  
SIG: sertraline 100 mg oral tablet, 30 days, Dispense #30 Tablet, 3 Refills, Directions: Take on tab daily  
6/12/2024 SAVARD,ZAINAB,NP

Current:  
SIG: Trileptal 150 mg oral tablet, 30 days, Dispense #60 Tablet, 3 Refills, Directions: Take one tab twice a day  
6/12/2024 SAVARD,ZAINAB,NP

ORDERS DETAIL

Order #290215  
Quest - All Lab Tests  
5/15/2024  
SAVARD,ZAINAB,NP

Test Code	Description	Diag1	Diag2	Diag3	Diag4
37848	LIPID PANEL W/ TRIGLYCERIDES/HD L-C	F33.2	F41.1		
10231	COMPREHENSIVE METABOLIC PANEL	F33.2	F41.1		
7444	THYROID PANEL WITH TSH	F33.2	F41.1		
19593	CBC (INCLUDES DIFF/PLT) (REFL)	F33.2	F41.1		
17306	VITAMIN D,25- OH,TOTAL,IA	F33.2	F41.1		

Order #291379  
Quest - All Lab Tests  
7/5/2024  
SAVARD,ZAINAB,NP

Test Code	Description	Diag1	Diag2	Diag3	Diag4
37848	LIPID PANEL W/ TRIGLYCERIDES/HD L-C	F33.2			
10231	COMPREHENSIVE METABOLIC PANEL	F33.2	F41.1		

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**DOB: 6/25/1985 AGE: 39 yrs. Acct#: 226**

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19593	DIFF/PLT) (REFL)	F41.1	F33.2
17306	VITAMIN D,25- OH,TOTAL,IA	F33.2	F41.1



<b>SAVARD, ZAINAB</b> 716 SEMINOLE BLVD LARGO, FL 33770-3627 phone: 7272383241 fax: 7272388402				<b>Quest</b> 716 SEMINOLE BLVD LARGO, FL 33770 Phone: 727-238-3241 Fax: 727-238-8402				
<b>Chart Patient Name</b>		<b>Patient ID</b>	<b>DOB (m/d/y)</b>	<b>Age</b>	<b>Sex</b>	<b>Reported Date/Time</b>	<b>Patient Phone</b>	<b>Second Phone</b>
Boerner, Stephen		226	06/25/1985	39 yrs.	M	5/31/2024 11:57PM		
<b>Comments</b>								
290215: CBC (INCLUDES DIFF/PLT) (REFL), COMPREHENSIVE METABOLIC PANEL, Enhanced PDF Report TZ639078P-1, LIPID PANEL W/ TRIGLYCERIDES/HDL-C, THYROID PANEL WITH TSH, VITAMIN D,25-OH,TOTAL,IA								
<b>Order ID / Tests / Diagnoses</b>								
<b>Ordering Provider</b>		<b>Collect Date &amp; Time</b>	<b>Date of Service</b>	<b>Status Change Date</b>	<b>Status</b>	<b>Signed</b>	<b>06/07/2024</b>	<b>Req. Number</b>
SAVARD, ZAINAB		5/29/2024 11:40 am	5/29/2024 11:41 am	5/31/2024 11:57pm	FINAL	HASSAN		TZ639078P
<b>Diagnostic Test / Results</b>		<b>Results</b>	<b>Out of Range</b>	<b>Flag</b>	<b>Units</b>	<b>Range</b>	<b>Site</b>	<b>Stat</b>
<b>COMPREHENSIVE METABOLIC PANEL [Final]</b>								
Glucose SerPI-mCnc		88		N	mg/dL	65-99	TP	F
<b>Notes</b>		Fasting reference interval						
BUN SerPI-mCnc		20		N	mg/dL	7-25	TP	F
Creat SerPI-mCnc		1.02		N	mg/dL	0.60-1.26	TP	F
eGFRcr SerPIBld CKD-EPI 2021		96		N	mL/min/1.73m2	> OR = 60	TP	F
BUN/Creat SerPI		SEE NOTE:			(calc)	6-22	TP	F
<b>Notes</b>		Not Reported: BUN and Creatinine are within reference range.						
Sodium SerPI-sCnc		139		N	mmol/L	135-146	TP	F
Potassium SerPI-sCnc		5.0		N	mmol/L	3.5-5.3	TP	F
Chloride SerPI-sCnc			97	L	mmol/L	98-110	TP	F
CO2 SerPI-sCnc			33	H	mmol/L	20-32	TP	F
Calcium SerPI-mCnc		9.9		N	mg/dL	8.6-10.3	TP	F
Prot SerPI-mCnc		7.9		N	g/dL	6.1-8.1	TP	F
Albumin SerPI-mCnc		5.0		N	g/dL	3.6-5.1	TP	F
Globulin Ser Calc-mCnc		2.9		N	g/dL (calc)	1.9-3.7	TP	F
Albumin/Glob SerPI		1.7		N	(calc)	1.0-2.5	TP	F
Bilirub SerPI-mCnc		0.6		N	mg/dL	0.2-1.2	TP	F
ALP SerPI-cCnc		64		N	U/L	36-130	TP	F
AST SerPI-cCnc		36		N	U/L	10-40	TP	F
ALT SerPI-cCnc			53	H	U/L	9-46	TP	F
<b>VITAMIN D,25-OH,TOTAL,IA [Final]</b>								
25(OH)D3+25(OH)D2 SerPI-mCnc			28	L	ng/mL	30-100	TP	F
<b>Notes</b>		Vitamin D Status      25-OH Vitamin D: Deficiency:              <20 ng/mL Insufficiency:            20 - 29 ng/mL Optimal:                  > or = 30 ng/mL For 25-OH Vitamin D testing on patients on D2-supplementation and patients for whom quantitation of D2 and D3 fractions is required, the QuestAssureD(TM) 25-OH VIT D, (D2,D3), LC/MS/MS is recommended: order code 92888 (patients >2yrs). See Note 1 Note 1  For additional information, please refer to <a href="http://education.QuestDiagnostics.com/faq/FAQ199">http://education.QuestDiagnostics.com/faq/FAQ199</a> (This link is being provided for informational/educational purposes only.)						





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**Boerner,Stephen - DOB: 6/25/1985**  
**Bokhari - EVERY PROVIDER NEEDS TO USE! - 5/15/2024**

**Copy and paste the Progress Note below:**

Chief of complains: New patient

**HPI:**

Patient presented to clinic of psych eval . Patient just moved from Philadelphia for family business. Patient reported that the business was falling off and reported that he has huge financial crises . Patient reported he was promised full benefits but he was not get any benefits or pay. Patient hired a lawyer since December and since then he has been dealing with stress, losing jobs, dealing with family issues. Patient reported that his house was broken in during March so that was added up to stress. Wife reported since broken, patient has trouble sleeping, covering the windows, feeling unsafe. Patient reported nightmares and avoiding sleeping scaring of the nightmares but has been better since he started on Hydroxyzine. Patient reported that guy invaded his house was under influence , he pressed charges , he was in jail but he was let it go by bond, he is pressured to go to court but he does not really want to deal with more legal issues, testimony and more court since he is already dealing with lawyer regarding to his job with family business.

Previous psychiatric treatment: ADHD, Adderall

Current medication: Olmesartan-Amlodipine HCTZ 40-5-25 mg, Hydroxyzine 25 mg, Zoloft 50 mg daily

Patient denied ... (Continued: in Endnote 1)

**MUST ENTER PATIENT'S ICD CODE IN THE PROGRESS  
NOTE! CLICK ON "ICD" BELOW TO ASSIGN THE CODE.**

Code	Description
F41.1	GENERALIZED ANXIETY DISORDER
F32.A	DEPRESSION, UNSPECIFIED
F43.10	POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED
F90.9	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYP...



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**Must checkmark at least one CPT code!**

**Office Visit Codes**

- ☐ 99215 - Office Visit
- ✓ 99205 - New Patient Office Visit
- ☐ 99417 - Plus 15 minutes (Prolonged visit)

**Psychotherapy**

- ☐ 96138 - Test given, by tech or physician, first 30 minutes.
- ☐ 96132 - Evaluation of tests done by physician

◆■❄□▼❄▲

**(1) Visit Date 5/15/2024 Continued:**

...suicidal.

Denied any involuntary hospitalization

**Psych Evaluation**

ROS:

**Depression:** reported of tearful depressed mood with poor motivation, isolating self; feeling withdrawn; hopeless; helpless; worthless; not able to concentrate, reported sleeping issues and nightmares, reported fatigue and increased aches and pains. PHQ-9 indicates: severe

**Anxiety:** complains of racing thoughts, rumination of thought, constant sense of worry, difficulty sleeping, feeling distracted by worry, irritable, restless with difficulty relaxing, with c/o muscle tension. Aggravating factors include: recent situation in HPI and noises like dog barking. The patient reports a history of panic attacks, classically described: palpitations, short of breath, and experienced 5 times during life but recently more often on average. GAD-7 score: severe

**Mania:** reported current irritable mood; denied euphoria; increased energy; feel jumpy or wired; reported decreased need for sleep in the past; trying to do several things at once believes themselves to be super intelligent or has special ability; denied risky behavior/impulsive behavior; reported some explosivity and racing thoughts but denied social than normal.

**Psychosis:** Denies auditory hallucinations; visual hallucinations or paranoia but reported sensitive to noises.

**OCD:** Reported some trace when it comes to certain projects

**ADHD:** at age 23, was taking Adderall but currently not taking due increase BP and made him detach,

**Eating Habits / Diet/Appetite:** denied any eating disorder. Eating well

**Sleep:** fair with Hydroxyzine

**Alcohol/Drug use:** denied any abused, drinks socially

**PAST PSYCH HISTORY:**

Past Psych Diagnoses: ADHD

Past Medication Trials: Adderall, Xanax (for short time due to job related)

Hospitalizations: Denied

Suicidality/Self Harm: Denied

**PAST MEDICAL HISTORY:** Hyperlipidemia

Current Medical Issues: denied

**SOCIAL HISTORY:**

Childhood/Family: Born and raised in Pennsylvania, raised by parents and still together

Education: Master in engineering

Exercise: Not currently

Current Living Situation: Lives in Gulfport living with wife, and dog

Work History: Currently not employed

Legal: denied

**FAMILY HISTORY:** 2 sibling, he is the youngest

Psychiatric: Depression, and Alcohol use disorder (father). Anxiety and depression (mother). Eating disorder (sister) No suicidal attempts in the family but reported sister had cutting issues

Medical: pacemaker at age 17 and HTN

History of abuse: denied

History of trauma or illness: reported with family business and having pacemaker at age young age, waking up during anesthesia during pacemaker procedure

History of TBI: had knocked off his chair and got hit by umbrella

**Appearance:** Age-appropriate build, posture, grooming; no prominent physical abnormalities; alert; cooperative

**Behavior:** appropriate and cooperative, calm, normal psychomotor and movements

**Speech:** Normal rate; good articulation; normal volume; fluent

**Mood:** depressed mood, tearful

**Affect:** Dysthymia

**Thought process:** patient reported normal thought process, he is able to understand his situation and wants to participate in his treatment

**Thought content:** Appropriate themes that occupy the patient's thoughts; no preoccupations, illusions, ideas of

reference, hallucinations, derealization, depersonalization, delusions

Cognition: Alert to person, place, time, situation; able to focus, sustain and appropriately shift mental attention.

Insight/Judgment: Intact, aware of his situation., able to anticipate the consequences of one's behavior and make decisions to safeguard your well-being and that of others

**Assessment:**

Major depressed disorder

General anxiety disorder

PTSD vs Acute distress disorder

ADHD

Less suspicion of Bipolar, but it could be bipolar 2

**Plan:**

-Increased Zoloft to 100 mg daily

-Continue on Hydroxyzine 25 mg prn

-Start on:

Trileptal 150 mg b.i.d

Guanfacine 1 mg at bedtime

- Encourage exercise at least 30 minutes daily

-Continue on psychotherapy

- Consider EMDR and CBT

-Labs were order (CBC, CMP, THS, VIT D, lipid panel)

-Patient is in process to find cardiology to check his pacemaker, last time was checked last year

-Follow up in a month

-Interventional management recommendations:

Spravato/Ketamine therapy /TMS

-Will offer QB test next visit

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Bokhari - EVERY PROVIDER NEEDS TO USE! - 6/12/2024**

**Copy and paste the Progress Note below:**

Chief of complains: Follow up

**HPI:**

Patient is doing well over all. He is tolerating the medications. Patient still dealing with family issues but he is handling it better. His wife wants to go back to Philadelphia but he feels he has more support here in FL but at the same time he wants to please his wife which makes him anxious

**Psych Evaluation**

**ROS:**

**Depression:** reported of tearful depressed mood with poor motivation, isolating self; feeling withdrawn; hopeless; helpless; worthless; not able to concentrate, reported sleeping issues and nightmares, reported fatigue and increased aches and pains. PHQ-9 indicates: 12

**Anxiety:** complains of racing thoughts, rumination of thought, constant sense of worry, difficulty sleeping, feeling distracted by worry, irritable, restless with difficulty relaxing, with c/o muscle tension . Aggravating factors include: recent situation in HPI and noises like dog barking. The patient reports a history of panic attacks, classically described: palpitations, short of breath, and experienced 5 times during life but recently more often on average. GAD-7 score: 13

**.Psychosis:** Denies auditory hallucinations; visual hallucinations or paranoia but reported sensitive to noises but has been improved ... (Continued: in Endnote 1)

**MUST ENTER PATIENT'S ICD CODE IN THE PROGRESS  
NOTE! CLICK ON "ICD" BELOW TO ASSIGN THE CODE.**

Code	Description
F32.A	DEPRESSION, UNSPECIFIED
F33.2	MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/O PSYCH FEATU...
F41.1	GENERALIZED ANXIETY DISORDER
F41.9	ANXIETY DISORDER, UNSPECIFIED
F90.9	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYP...

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**Office Visit Codes**

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- ☐ 99417 - Plus 15 minutes (Prolonged visit)

**Psychotherapy**

- ☒ 96138 - Test given, by tech or physician, first 30 minutes.
- ☐ 96132 - Evaluation of tests done by physician

◆■❄■□▼❄▲

**(1) Visit Date 6/12/2024 Continued:**

...

**Mental exam:**

**Appearance:** Age-appropriate build, posture, grooming; no prominent physical abnormalities; alert; cooperative

**Behavior:** appropriate and cooperative, calm, normal psychomotor and movements

**Speech:** Normal rate; good articulation; normal volume; fluent

**Mood:** euthymic

**Affect:** normal

**Thought process:** patient reported normal thought process, he is able to understand his situation and wants to participate in his treatment

**Thought content:** Appropriate themes that occupy the patient's thoughts; no preoccupations, illusions, ideas of reference, hallucinations, derealization, depersonalization, delusions

**Cognition:** Alert to person, place, time, situation; able to focus, sustain and appropriately shift mental attention.

**Insight/Judgment:** Intact, aware of his situation., able to anticipate the consequences of one's behavior and make decisions to safeguard your well-being and that of others

**Assessment:**

Major depressed disorder

General anxiety disorder

PTSD vs Acute distress disorder

ADHD

Less suspicion of Bipolar, but it could be bipolar 2

**Medical:**

Pace maker as teen due to sinus sick syndrome

Hyperlipidemia

**Plan:**

Continue on

-Zoloft to 100 mg daily

-Hydroxyzine 25 mg pm

- Trileptal 150 mg b.i.d

-Guanfacine 1 mg at bedtime

- Encourage exercise at least 30 minutes daily

-Continue on psychotherapy

- Consider EMDR and CBT

-Labs reviewed with the patient

-Patient is in process to find cardiology to check his pacemaker, last time was checked last year

-QB test today

-Follow up to review QB test

-Interventional management recommendations:

Spravato/Ketamine therapy /TMS

Patient Information	Specimen Information	Client Information
<b>BOERNER, STEPHEN</b>  <b>DOB: 06/25/1985    AGE: 38</b> Gender: M Phone: 215.530.0545 Patient ID: 226 Health ID: 8573033575988556	Specimen: TZ639078P Requisition: 0000020 Lab Ref #: 290215  Collected: 05/29/2024 / 11:40 EDT Received: 05/29/2024 / 21:11 EDT Reported: 05/31/2024 / 23:57 EDT	Client #: 11559113    11TL999 SAVARD, ZAINAB BOKHARI MEDICAL CONSORTIUM 716 SEMINOLE BLVD LARGO, FL 33770-3627

Test Name	In Range	Out Of Range	Reference Range	Lab
THYROID PANEL WITH TSH				
THYROID PANEL				TP
T3 UPTAKE	30		22-35 %	
<b>T4 (THYROXINE), TOTAL</b>		<b>4.8 L</b>	4.9-10.5 mcg/dL	
FREE T4 INDEX (T7)	1.4		1.4-3.8	
TSH	2.00		0.40-4.50 mIU/L	TP
COMPREHENSIVE METABOLIC PANEL				TP
GLUCOSE	88		65-99 mg/dL	
Fasting reference interval				
UREA NITROGEN (BUN)	20		7-25 mg/dL	
CREATININE	1.02		0.60-1.26 mg/dL	
EGFR	96		> OR = 60 mL/min/1.73m2	
BUN/CREATININE RATIO	SEE NOTE:		6-22 (calc)	
Not Reported: BUN and Creatinine are within reference range.				
SODIUM	139		135-146 mmol/L	
POTASSIUM	5.0		3.5-5.3 mmol/L	
<b>CHLORIDE</b>		<b>97 L</b>	98-110 mmol/L	
<b>CARBON DIOXIDE</b>		<b>33 H</b>	20-32 mmol/L	
CALCIUM	9.9		8.6-10.3 mg/dL	
PROTEIN, TOTAL	7.9		6.1-8.1 g/dL	
ALBUMIN	5.0		3.6-5.1 g/dL	
GLOBULIN	2.9		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.7		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.6		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	64		36-130 U/L	
AST	36		10-40 U/L	
<b>ALT</b>		<b>53 H</b>	9-46 U/L	
CBC (INCLUDES DIFF/PLT) (REFL)				TP
WHITE BLOOD CELL COUNT	8.0		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	5.31		4.20-5.80 Million/uL	
HEMOGLOBIN	16.2		13.2-17.1 g/dL	
HEMATOCRIT	48.3		38.5-50.0 %	
MCV	91.0		80.0-100.0 fL	
MCH	30.5		27.0-33.0 pg	
MCHC	33.5		32.0-36.0 g/dL	
RDW	12.0		11.0-15.0 %	
PLATELET COUNT	330		140-400 Thousand/uL	
MPV	9.3		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	5080		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2000		850-3900 cells/uL	
ABSOLUTE MONOCYTES	768		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	88		15-500 cells/uL	
ABSOLUTE BASOPHILS	64		0-200 cells/uL	
NEUTROPHILS	63.5		%	
LYMPHOCYTES	25.0		%	
MONOCYTES	9.6		%	
EOSINOPHILS	1.1		%	

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Test Name	In Range	Out Of Range	Reference Range	Lab
BASOPHILS	0.8		%	



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Endocrinology

Test Name	Result	Reference Range	Lab
<b>VITAMIN D,25-OH,TOTAL,IA</b>	<b>28 L</b>	30-100 ng/mL	TP
Vitamin D Status                      25-OH Vitamin D: Deficiency:                                      <20 ng/mL Insufficiency:                                      20 - 29 ng/mL Optimal:    > or = 30 ng/mL  For 25-OH Vitamin D testing on patients on D2-supplementation and patients for whom quantitation of D2 and D3 fractions is required, the QuestAssureD(TM) 25-OH VIT D, (D2,D3), LC/MS/MS is recommended: order code 92888 (patients >2yrs).			
For additional information, please refer to <a href="http://education.QuestDiagnostics.com/faq/FAQ199">http://education.QuestDiagnostics.com/faq/FAQ199</a> (This link is being provided for informational/ educational purposes only.)			
Physician Comments:			

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### Cardio IQ<sup>®</sup>

Test Name	Current		Risk/Reference Interval			Historical
	Result & Risk		Optimal	Moderate	Units	Result & Risk
	Optimal	Non-Optimal				
LIPID PANEL W/ TRIGLYCERIDES/HDL-C						
CHOLESTEROL, TOTAL			<200	N/A	>=200	mg/dL
HDL CHOLESTEROL	61		>=40	N/A	<40	mg/dL
TRIGLYCERIDES	135		<150	150-199	>=200	mg/dL
LDL CHOLESTEROL			<100	100-129	>129	mg/dL (calc)
CHOL/HDL C		3.8	<=3.5	3.6-5.0	>5.0	calc
NON HDL CHOLESTEROL		173	<130	130-189	>=190	mg/dL (calc)
TG/HDL C		2.2	<2.0	2.0-3.0	>3.0	calc

For details on reference ranges please refer to the reference range/comment section of the report.

**Medical Information For Healthcare Providers:** If you have questions about any of the tests in our Cardio IQ offering, please call Client Services at our Quest Diagnostics-Cleveland HeartLab Cardiometabolic Center of Excellence. They can be reached at 866.358.9828, option 1 to arrange a consult with our clinical education team.

Patient Information	Specimen Information	Client Information
<b>BOERNER, STEPHEN</b>  <b>DOB: 06/25/1985    AGE: 38</b> Gender: M Patient ID: 226 Health ID: 8573033575988556	Specimen: TZ639078P Collected: 05/29/2024 / 11:40 EDT Received: 05/29/2024 / 21:11 EDT Reported: 05/31/2024 / 23:57 EDT	Client #: 11559113 SAVARD, ZAINAB

Reference Range/Comments				
Analyte Name	In Range	Out Range	Reference Range	Lab
CHOLESTEROL, TOTAL		234	<200 mg/dL	Z4M
LDL CHOLESTEROL		147	<100 mg/dL (calc)	Z4M
Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with >= 2 CHD risk factors. LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the estimation of LDL-C. Martin SS et al. JAMA. 2013;310(19): 2061-2068 ( <a href="http://education.QuestDiagnostics.com/faq/FAQ164">http://education.QuestDiagnostics.com/faq/FAQ164</a> )				
NON HDL CHOLESTEROL		173	<130 mg/dL (calc)	Z4M
For patients with diabetes plus 1 major ASCVD risk factor, treating to a non-HDL-C goal of <100 mg/dL (LDL-C of <70 mg/dL) is considered a therapeutic option.				
TG/HDL C		2.2	<2.0 calc	Z4M
CHOL/HDL C	3.8		<5.0 calc	Z4M
HDL CHOLESTEROL	61		>39 mg/dL	Z4M
TRIGLYCERIDES	135		<150 mg/dL	Z4M

**PERFORMING SITE:**

TP QUEST DIAGNOSTICS-TAMPA, 4225 E. FOWLER AVE, TAMPA, FL 33617-2026 Laboratory Director: WESTON H ROTHROCK, MD, CLIA: 10D0291120  
Z4M CLEVELAND HEARTLAB INC, 6701 CARNEGIE AVENUE SUITE 500, CLEVELAND, OH 44103-4623 Laboratory Director: SAMI ALBEIROTI, PHD, DABCC, CLIA: 36D1032987