which all three manifestations of type 1 diabetes mellitus (T1DM), primary adrenal insufficiency, and hypothyroidism were found and diagnosed at the same time. **Case Description:** A 32-year-old male with suspected alcohol abuse presented to the hospital with nausea, vomiting, and weakness of two weeks duration after sustaining a fall. He was admitted for Diabetic Ketoacidosis (DKA) and shock requiring three pressors with unclear etiology. Labs were significant for severe hyponatremia of 113 mmol/L (136-145), elevated anion gap of 22, glucose 206 mg/dL (70-100), bicarbonate 11 mmol/L (21-31), beta hydroxybutyrate 5.90 mmol/L (0.0-0.42), and pH 7.22 (7.35-7.45) with Hemoglobin A1c 14.5% (<5.7). An insulin drip was instituted for DKA and the hyponatremia persisted. Cortisol was found to be suppressed at 3.0 ug/dL (3.1-22.4) with significantly elevated ACTH 220.4 pg/mL (7.2-63.3) suggesting a new diagnosis of primary adrenal insufficiency. IV hydrocortisone 100 mg q8H was started on day 2 of hospitalization. Thyroid labs showed elevated TSH 10.10 uIU/mL (0.36-3.74) confirming hypothyroidism, prompting initiation of IV levothyroxine. His hospital course was complicated by cardiac arrest and acute respiratory failure requiring intubation. Cardiac work up was negative except for severe non-ischemic cardiomyopathy with significantly reduced ejection fraction of 20-25%. Bronchoscopy was performed and showed no evidence of obstructing pulmonary etiologies. SARS Coronavirus PCR was negative. He also had shock liver along with Disseminated intravascular coagulation (DIC). His kidney function worsened requiring continuous kidney replacement therapy (CRRT). Urine microscopy showed granular casts consistent with acute tubular necrosis. TPO antibodies, adrenal antibodies, GAD antibodies, and Zinc Transporter 8 antibodies all came back positive along with an undetectable C-peptide confirming the diagnosis of Hashimotos hypothyroidism, primary adrenal insufficiency, and T1DM respectively. He was eventually discharged on basal bolus insulin regimen, levothyroxine 75 mcg po daily, fludrocortisone 0.05 mg po daily, and prednisone 5 mg po daily. The patient had multifactorial shock from an acute presentation of DKA, primary adrenal insufficiency, and hypothyroidism all presenting simultaneously. **Conclusion:** This case illustrates the severe impact of having three endocrine organs affected all at once. The prevalence of Schmidt syndrome is very low at 1:20,000 in the general population and can be associated with other non-endocrine autoimmune disorders. Prevalence of autoimmune thyroid disease is 70%, T1DM 50%, and Addison’s disease is almost 100%. Due to the low prevalence, one needs a high clinical suspicion with the correct lab findings to diagnose this disease. Incorrect diagnoses or a late diagnosis can lead to life threatening consequences to the patient. The mainstay of treatment is hormone replacement, with corticosteroids given before thyroid replacement.

**Presentation:** No date and time listed