Cincinnati Children's
changing the outcome together

Cincinnati Children's Clinical Laboratories

For test inquiries please call: 513.636.4530 • Fax: 513.803.5056

MMP-7 TEST REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____ (Last) , _____ (First) , _____ (MI)

MR# _____ Date of Birth _____ / _____ / _____

Gender: ☐ Male ☐ Female

SAMPLE/SPECIMEN INFORMATION

Sample Type: Please check one

Serum _____ Lt Li Hep Plasma _____

Collection Date: _____ / _____ / _____

Collection Time: _____

TEST REQUESTED

☐ **MMP-7 (Matrix Metalloproteinase-7)**

1 mL Red top Serum or Lt Li Hep Plasma*
spun, separated, and frozen within 2 hrs. of collection; ship on dry ice.

(Turnaround time 1-3 days, same day if received Monday through Friday)

BILLING INFORMATION

☐ REFERRING INSTITUTION

Institution: _____

Address: _____ City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____ Fax: _____

Email: _____

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

SHIPPING

Ship Sample to (Monday to Friday delivery only)

Division of Nephrology Clinical Lab T6-325

CCHMC S Building, Dock 1

240 Albert Sabin Way, Cincinnati, OH 45229-3039

Please call 513 636 4530 for weekend shipping instructions.