Cincinnati Children's
changing the outcome together

Cincinnati Children's Clinical Laboratories

For test inquiries please call: 513.636.4530 • Fax: 513.803.5056

MMP7 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

☐ **MMP7 (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.

* Place specimen on ice after collection and deliver to lab immediately

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:
Division of Nephrology Clinical Lab T6-325
CCHMC S Building, Dock 1
240 Albert Sabin Way, Cincinnati, OH 45229-3039