

DIVISION OF NEPHROLOGY RESEARCH TESTING REQUISITION

For test inquiries please call:
Phone: **513-636-4530**
Fax: **513-803-5056**
Email: **nephclinicallab@cchmc.org**
www.cincinnatichildrens.org/nephrology-labtests

Ship to:
Cincinnati Children's
Division of Nephrology Laboratory
240 Albert Sabin Way T-6 325, Dock 1
Cincinnati Ohio 45229



NEPHROLOGY RESEARCH REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

REQUESTOR

Institution: _____

Address: _____

PI: _____ Quote: _____

Coordinator: _____

Email: _____ Telephone: _____

TEST / SAMPLE INFORMATION

Samples Shipped: YES NO _____ Date: _____

Sample Type: _____ Clinical Trial: YES NO

Test Requested: _____

BILLING CONTACT

Name: _____

Email: _____ Telephone: _____

Study / Grant information : _____

SHIPPING

Ship Samples to:
Cincinnati Children's Hospital Medical Center
Division of Nephrology Laboratory
240 Albert Sabin Way T-6 325, Dock 1
Cincinnati Ohio 45229

Please include a manifest and e-mail sample log to Thelma.Kathman@cchmc.org