Cincinnati Children's
changing the outcome together

Cincinnati Children's Clinical Laboratories

For test inquiries please call: 513.803.8392 • Fax: 513.636.7805

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: Serum

Collection Date: _____ / _____ / _____

Collection Time: _____

TEST REQUESTED

☐ **MMP7 (Matrix Metalloproteinase 7)**

1 mL Red/Gold Top Serum Tube
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:
Cincinnati Children's Hospital Medical Center
Division of Gastroenterology, Lab T9-350
CCHMC S Building, Dock 1
240 Albert Sabin Way
Cincinnati, OH 45229-3039