LABMISC
EX0155-001NS Rev.10/2023

CHILDREN'S HEALTH
Clinical Laboratories
For test inquiries please call:
214-456-2320 • Fax: 214-456-5163

MMP7 Test Requisition

Place a patient label on all sheets

Location: _____

Patient Name: _____

DOB: _____

Medical Record Number: _____

CSN: _____

All Information Must Be Completed Before Sample Can Be Processed

PATIENT INFORMATION

SAMPLE / SPECIMEN INFORMATION

Patient Name: _____ , _____ , ____ **Sample Type: Serum**
Last **First** **MI**

MR#: _____ **Date of Birth:** ____ / ____ / _____ **Collection Date:** ____ / ____ / _____

Gender: ☐ **Male** ☐ **Female** ☐ **Other** **Collection Time:** _____

TEST REQUESTED

☐ **MMP7 (Matrix Metalloproteinase 7)**
1 mL Red / Gold Top Serum Tube
Collection Instructions: Place specimen on ice after collection and deliver to lab immediately.
Laboratory Instructions: Specimen should be spun, separated, and frozen within 2 hrs. of collection; ship on dry ice.

REFERRING INSTITUTION BILLING INFORMATION

Laboratory will bill referring institution; Laboratory will not bill patient

Referring Institution: _____

Address: _____ **City / State / Zip:** _____

Accounts Payable Contact Name: _____

Phone: _____ **Fax:** _____

Email: _____

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (____) _____ **Fax:** (____) _____ **Email:** _____

SHIPPING

SHIP SAMPLES TO:
Metabolic Laboratory
Children's Medical Center
1935 Medical District Drive
Dallas, TX 75235