children's health

Children's Health Clinical Laboratories

For test inquiries please call: 214-456-2320 • Fax: 214-456-5163

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: _____

SHIPPING

Ship Samples to:
Metabolics Laboratory
Children's Medical Center
1935 Medical District Drive
Dallas, Tx 75235