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: _____ (Last), _____ (First), ____ (MI)

Sample Type: Serum

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: _____

Invoices should be sent to:
St. Louis Children's Hospital
1 Children's Place
St. Louis, MO 63110
Attn: Laboratory Administration Room 2N62

REFERRING PHYSICIAN

Physician Name (print): _____

Address: 1 Children's Pl, St. Louis, MO 63110

Phone: (____) _____ **Fax:** (314) 454-4156 **Email:** _____

SHIPPING

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