635 Columbia Street
New Westminster, BC
Canada V3M 1A7

ORCHID CELLMARK

1-800-563-4363 (english)
1-800-565-4505 (français)
Facsimile: 604-523-2974

KINSHIP TESTING APPLICATION
(Curiosity)

To initiate a DNA test, please complete this form and fax or mail to Orchid Cellmark.
A customer service associate will supply the clients directly with cheek swab collection kits.

Referred by: Internet

PARTIES TO BE TESTED

CLIENT	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	
	Phone #	Date of Birth:
CLIENT	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	
	Phone #	Date of Birth:
CLIENT	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	
	Phone #	Date of Birth:
CLIENT	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	
	Phone #	Date of Birth:

ADDITIONAL INFORMATION:

Have client(s) been tested with Orchid Cellmark / Helix Biotech before? ❑ Yes ❑ No | If yes, previous case number: ________________

DNA TESTING NEEDS – Please provide information on the objective of the DNA test

On a separate piece of paper, please indicate any information regarding the paternal and maternal lineage of each person as well as their relationships to the other tested parties. Please specify if the relationships are known or alleged.

PAYMENT INFORMATION - Please note that applicable taxes will be added to the price

* The price for testing two parties is $850 (this includes testing one mother). Each additional person tested at the same time is an additional $175.
* The price to test a new person at a later date is $525 plus $50 for each sample that is re-used. Samples are stored for one year only.
* Non-cheek swab samples submitted for testing are subject to a $250 surcharge. Taxes are exempt with a completed Doctor referral (at bottom).
* If this case is cancelled at any time prior to testing, there will be a $100 non-refundable administration fee.

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:

❑ Payment is included (Please send a certified cheque or money order payable to Orchid Cellmark)

❑ Please charge my Visa, MasterCard or American Express #:____Exp:____________

Name of Card Holder:____Signature ____________________________

Address of Cardholder if different than person receiving results:

DOCTOR REFERRAL (To be completed by Physician)

OPTIONAL - REQUIRED FOR TAX EXEMPTION ONLY

Referring Physician	
Address	
City/Prov/PC	
Phone #	
Signature	Date

PATIENT NAME:

Reason for Referral

❑ Relieve stress and anxiety brought on as a result of uncertainty about paternity
❑ To determine paternity for family involvement and support
❑ Other (please specify):