

PATERNITY 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		Orchid Case #
M O T H E R	Name	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Date of Birth:
	City/Prov /PC	Phone #
C H I L D	Name	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address <small>(If different than guardian parent)</small>	Date of Birth:
	City/Prov /PC	Gender: Male / Female
A L L E G E D F A T H E R	Name	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Date of Birth:
	City/Prov /PC	Phone #
O T H E R	Name	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to case: <input type="checkbox"/> Another Alleged Father <input type="checkbox"/> Another Child	Date of Birth:
	Address	Gender: Male / Female
	City/Prov /PC	Phone:
ADDITIONAL INFORMATION:		
Have client(s) been tested with Orchid Cellmark / Helix Biotech before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, previous case number: _____
Is there more than one possible father of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is the other possible father a brother of the alleged father? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PAYMENT INFORMATION - Please note that applicable taxes will be added to the price		
<ul style="list-style-type: none"> * The price to test a mother, child and alleged father is \$375. Each additional person tested at the same time is an additional \$175. * The price to test a new person at a later date is \$175 plus \$50 for each sample that is re-used. Samples are stored for one year only. * Please note that 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:		
<input type="checkbox"/> Payment is included (Please send a certified cheque or money order payable to Orchid Cellmark)		
<input type="checkbox"/> Please charge my Visa, MasterCard or American Express #: _____ Exp: _____		
Name of Cardholder	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address	Phone #	
City/Prov/PC	Signature:	
DOCTOR REFERRAL (To be completed by Physician)		PATIENT NAME:
<small>OPTIONAL - REQUIRED FOR TAX EXEMPTION ONLY</small>		Reason for Referral <input type="checkbox"/> Relieve stress and anxiety brought on as a result of uncertainty about paternity <input type="checkbox"/> To determine paternity for family involvement and support <input type="checkbox"/> Other (please specify): _____
Referring Physician		
Address		
City/Prov/PC		
Phone #		
Signature	Date	