

GRANDPARENT TESTING APPLICATION (Court Ready)

To initiate a DNA test, please complete this form and fax or mail to Orchid Cellmark. A customer service associate will contact the clients directly to arrange for sample collection at a convenient collection site. Results will be forwarded to each adult party tested.

Referred by:

PARTIES TO BE TESTED		Orchid Case #
M O T H E R	Name	Date of Birth:
	Address	Phone #
	City/Prov	Email:
	Postal Code:	
C H I L D	Name	Date of Birth:
	Address	Phone #
	City/Prov	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Postal Code:	Email:
G R A N D M O T H E R	Name	Date of Birth:
	Address	Phone #
	City/Prov	Email:
	Postal Code:	
G R A N D F A T H E R	Name	Date of Birth:
	Address	Phone #
	City/Prov	Email:
	Postal Code:	

ADDITIONAL INFORMATION:

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

Is there more than one possible father of this child? Yes No If yes, is the other possible father a brother of the alleged father? Yes No

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

- * The price to test a mother, child and both paternal grandparents is \$800.
- * The price to test a mother, child and one paternal grandparent is \$950.
- * Each additional person tested at the same time is an additional \$200.
- * The price to test a new person at a later date is \$200 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 except bone and teeth which are \$600/sample.
- * Taxes are exempt with a completed Doctor referral (at bottom).
- * Full payment for services is required prior to setting up the specimen collection appointments.
- * 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	PATIENT NAME:
Referring Physician	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): _____
Address	
City/Prov/PC	
Phone #	
Signature _____ Date _____	