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

GRANDPARENT 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:

PARTIES TO BE TESTED		Orchid Case #
MOTHER	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	
	Phone #	Date of Birth:
CHILD	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	Gender: ❑ Male ❑ Female
	Phone #	Date of Birth:
GRAND MOTHER	Name	**To Receive Test Results** ❑ Yes ❑ No
	Address	
	City/Prov /PC	
	Phone #	Date of Birth:
GRAND FATHER	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: ___________________

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 $550.
* The price to test a mother, child and one paternal grandparent is $725.
* 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.
* If clients wish to receive cheek swab kits by Xpress Post, there will be a charge of $15 per address.
* Non-cheek swab samples submitted for testing are subject to a $250 surcharge except bone and teeth, which are $600/sample.
* 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:

❑ 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**
Address	❑ Relieve stress and anxiety brought on as a result of uncertainty about paternity
City/Prov/PC	❑ To determine paternity for family involvement and support
Phone #	❑ Other (please specify):
Signature Date	