

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:

PARTIES TO BE TESTED		Orchid Case #
C L I E N T	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Date of Birth:
	City/Prov /PC	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #	Email:
C L I E N T	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Date of Birth:
	City/Prov /PC	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #	Email:
C L I E N T	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Date of Birth:
	City/Prov /PC	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #	Email:
C L I E N T	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Date of Birth:
	City/Prov /PC	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #	Email:

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 and one of their mothers 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.
- * Non-cheek swab samples submitted for testing are subject to a \$250 surcharge except bone and teeth which are \$600/sample.
- * If clients wish to receive cheek swab kits by Xpress Post, there will be a charge of \$15 per address.
- * 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): _____