

MATERNITY 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 #
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 #
C H I L D	Name	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address (If different than guardian parent)	Date of Birth:
	City/Prov /PC	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
A L L E G E D 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 #
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 Mother <input type="checkbox"/> Another Child	Date of Birth:
	Address	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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 mother of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is the other possible mother a sister of the alleged mother? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

- * The price to test a father, child and alleged mother is \$375. Each additional person tested at the same time is an additional \$175.
- * The price for each non-cheek swab sample is \$250/sample except for 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.
- * 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:

- 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 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)
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): _____