

## Mitochondrial DNA Matrilineage Application Form (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	To Receive a Collection Kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	City/Prov /PC		
	Phone #	Date of Birth:	
C L I E N T	Name	To Receive Test Results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	To Receive a Collection Kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	City/Prov /PC		
	Phone #	Date of Birth:	
C L I E N T	Name	To Receive Test Results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	To Receive a Collection Kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	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: \_\_\_\_\_

### RELATIONSHIP TO BE TESTED (Please describe the suspected relationship between these parties)

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

\* The price for each party tested is \$1450.

\* 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):