

PATERNITY 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 specimen collection at a convenient collection site. Results will be forwarded to each adult party tested.

Referred by:

PARTIES TO BE TESTED									
M O T H E R	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Name</td> <td>Date of Birth:</td> </tr> <tr> <td>Address</td> <td>Phone:</td> </tr> <tr> <td>City/Prov /PC</td> <td>Email:</td> </tr> </table>	Name	Date of Birth:	Address	Phone:	City/Prov /PC	Email:		
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Address	Phone:								
City/Prov /PC	Email:								
C H I L D	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Name</td> <td>Date of Birth:</td> </tr> <tr> <td>Address <small>(if different from guardian parent)</small></td> <td>Gender: Male / Female</td> </tr> <tr> <td>City/Prov /PC</td> <td>Phone:</td> </tr> <tr> <td></td> <td>Email:</td> </tr> </table>	Name	Date of Birth:	Address <small>(if different from guardian parent)</small>	Gender: Male / Female	City/Prov /PC	Phone:		Email:
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Name	Date of Birth:								
Relationship to case: <input type="checkbox"/> Another Alleged Father <input type="checkbox"/> Another Child	Gender: Male / Female								
Address	Phone:								
City/Prov /PC	Email:								
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 father of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is the other possible father a brother of the alleged father? <input type="checkbox"/> Yes <input type="checkbox"/> No								
PAYMENT INFORMATION - Please note that applicable taxes will be added to the price									
<p>* The price to test a mother, child and alleged father is \$600. 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. * Please note that 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.</p>									
PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:									
<input type="checkbox"/> Payment is included (Please send a certified cheque or money order payable to Orchid Cellmark)									
<input type="checkbox"/> 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) <small>OPTIONAL - REQUIRED FOR TAX EXEMPTION ONLY</small>									
Referring Physician	Reason for Referral								
Address	<input type="checkbox"/> Relieve stress and anxiety brought on as a result of uncertainty about paternity								
City/Prov/PC	<input type="checkbox"/> To determine paternity for family involvement and support								
Phone #	<input type="checkbox"/> Other (please specify):								
Signature	Date								