

PATERNITY TESTING APPLICATION (Lawyer)

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 or legal representative.

Referred by:

PARTIES TO BE TESTED	
Mother:	Phone:
Address	Date of Birth:
City/Prov /PC	Email:
Child #1:	Date of Birth:
Child #2:	Date of Birth:
Alleged Father:	Phone:
Address	Date of Birth:
City/Prov /PC	Email:

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

LEGAL REPRESENTATIVES & OTHER AGENCIES

Court Date:

Name:	Representing: <input type="radio"/> Mother <input type="radio"/> Child <input type="radio"/> Alleged Father
Organization:	Phone:
Address:	Fax:
City/Prov /PC:	Email:
Name:	Representing: <input type="radio"/> Mother <input type="radio"/> Child <input type="radio"/> Alleged Father
Organization:	Phone:
Address:	Fax:
City/Prov /PC:	Email:
Name:	Representing: <input type="radio"/> Mother <input type="radio"/> Child <input type="radio"/> Alleged Father
Organization:	Phone:
Address:	Fax:
City/Prov /PC:	Email:

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

- * 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.
- * Full payment or authorization 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.

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:

Please charge my Visa, MasterCard or American Express #: _____ Exp: _____

Name of Card Holder: _____ Signature _____

Address of Cardholder if different than person receiving results:

- Payment is included (Please send a certified cheque or money order payable to Orchid Cellmark)
- Attached is a letter stating funds are being held in trust for the mother / child / alleged father
- Attached is a copy of the government authorization to pay