

PRE-NATAL PATERNITY TESTING APPLICATION (Court Ready)

To initiate a paternity test, please complete this form and fax or mail to Orchid Cellmark. Please note that the mother's sample must be taken on the same day, or before, the fetal sample. Results will be forwarded to each adult party tested.

Referred by: **Internet**

PARTIES TO BE TESTED		Orchid Case #
M O T H E R	Name	Date of Birth:
	Address	Email:
	City/Prov/PC	Due Date:
	Phone #	
F E T U S	The written report will use "Baby" followed by the Mother's Last Name	Type of Pre-natal sample (please check one)
	Date of Amniocentesis/CVS Collection:	<input type="checkbox"/> CVS
	Name of Hospital:	<input type="checkbox"/> Amniotic fluid
A L L E G E D F A T H E R	Name	Date of Birth:
	Address	Email:
	City/Prov/PC	
	Phone #	

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

PHYSICIAN INFORMATION (Please indicate the name of the doctor who will be collecting the pre-natal sample)

D O C T O R	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	
	City/Prov/PC	
	Phone #	

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

- * The price to test a mother, fetal sample and alleged father is \$850. 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 from the mother and/or the alleged father are subject to a \$250 surcharge.
- * 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.

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	PATIENT NAME:
Referring Physician	Reason for Referral <input type="checkbox"/> Relieve stress and anxiety brought on as a result of uncertainty about paternity <input type="checkbox"/> To determine paternity for family involvement and support <input type="checkbox"/> Other (please specify):
Address	
City/Prov/PC	
Phone #	
Signature _____ Date _____	