

TWIN ZYGOSITY DNA 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 person requesting testing.

Referred by:

PARTIES TO BE TESTED		Orchid Case #	
Child #1	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child #2	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race of children (Please circle one): <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Aboriginal Other			

ADDITIONAL INFORMATION:

Have client(s) been tested with Orchid Cellmark / Helix Biotech before? Yes No If yes, previous case number: _____

PERSON REQUESTING TEST

Name
Relationship to above individuals:
Address
City/Prov /PC
Phone #
Email:

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

- * The price to test both twins 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.

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):