

## TWIN ZYGOSITY DNA TESTING APPLICATION (Curiosity)

To initiate a DNA test, please complete this form and fax or mail to Orchid Cellmark. A customer service associate will send the cheek swab collection kits to the person requesting the test. 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: <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 \$375. Each additional person tested at the same time is an additional \$175.
- \* The price for any non-cheek swab sample is \$250/sample except bone and teeth which are \$600/sample.
- \* If clients wish to receive cheek swab kits by Xpress Post, there will be a charge of \$15 per address.
- \* The price to test a new person at a later date is \$175 plus \$50 for each sample that is re-used. Samples are stored for one year only.
- \* Please note that taxes are exempt with a completed Doctor referral (at bottom).
- \* 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):