Orchid PRO DNA

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LEGAL DNA TEST APPLICATION

Lawyer

Please complete this form and email, fax or mail to the location indicated above. A customer service associate will contact the clients directly to arrange appointments for cheek swab collection. **The test report will be sent to all legal representatives and to any adult party who is not legally represented**.

DNA TEST REQUIRED: ☐ Paternity ☐ Maternity ☐ Grandparent ☐ Sibship ☐ Half Sibship ☐ Other _____

REQUESTED BY: _____ DATE: _____

PARTIES TO BE TESTED

If client(s) have previously been tested with our lab, please provide case number: _____

CLIENT #1	Name:				Date of Birth (yyyy/mm/dd):
	Address:			Apt.:	Phone:
	City:	Prov:	Postal Code:		Email:
	Role: ☐ Mother ☐ Child ☐ Father ☐ Other (please specify):				
CLIENT #2	Name:				Date of Birth (yyyy/mm/dd):
	Address:			Apt.:	Phone:
	City:	Prov:	Postal Code:		Email:
	Role: ☐ Mother ☐ Child ☐ Father ☐ Other (please specify):				
CLIENT #3	Name:				Date of Birth (yyyy/mm/dd):
	Address:			Apt.:	Phone:
	City:	Prov:	Postal Code:		Email:
	Role: ☐ Mother ☐ Child ☐ Father ☐ Other (please specify):				
CLIENT #4	Name:				Date of Birth (yyyy/mm/dd):
	Address:			Apt.:	Phone:
	City:	Prov:	Postal Code:		Email:
	Role: ☐ Mother ☐ Child ☐ Father ☐ Other (please specify):				

ADDITIONAL INFORMATION

For paternity cases, is there a first degree relative (brother, father) of the man being tested who may possibly be the father of this child? ☐ Yes ☐ No

For maternity cases, is there a first degree relative (sister, mother) of the woman being tested who may possibly be the mother of this child? ☐ Yes ☐ No

LEGAL REPRESENTATIVES & OTHER AGENCIES

Name:			Representing:
Organization:			Phone:
Address:			Fax:
City:	Prov:	Postal Code:	Email:
Delivery of Test Report (Please choose one): ☐ Regular Mail ☐ Fax ☐ Web portal (please provide email address above)			

Name:			Representing:
Organization:			Phone:
Address:			Fax:
City:	Prov:	Postal Code:	Email:
Delivery of Test Report (Please choose one): ☐ Regular Mail ☐ Fax ☐ Web portal (please provide email address above)			

PAYMENT INFORMATION

* Full payment or authorization for services is required prior to sample collection.
* For kinship testing and non-cheek swab samples, additional fees will apply. Please call for pricing.
* An administrative fee will apply if this case is cancelled at any time prior to testing.

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:

☐ Payment is included (If a private party is paying, please send a certified cheque or money order payable to Orchid PRO-DNA).
☐ Attached is a letter stating funds are being held in trust. The laboratory will send an invoice upon receipt of the last sample in the case.
☐ Please charge my ☐ Visa ☐ MasterCard or ☐ American Express #:_____ Exp:_____

Name of Cardholder:			Phone:
Credit Card Billing Address:			Signature:
City:	Prov:	Postal Code:	Date: