Orchid PRO DNA

www.orchidprodna.ca
info@orchidprodna.ca

☐ 3885 Industriel Blvd.
Laval, QC, Canada H7L 4S3
Tel 450.901.3072 / 1.800.565.4505
Fax 450.901.3082

☐ 2985 Virtual Way, Suite 265
Vancouver, BC, Canada V5M 4X7
Tel 604.523.2945 / 1.800.563.4363
Fax 604.523.2974

LEGAL DNA TEST APPLICATION
Government

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: For kinship testing and non-cheek swab samples, additional fees will apply.

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

ADDITIONAL INFORMATION

Is there a first degree relative of the person being tested who may possibly be the father/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 OPTIONS - Full payment or authorization for services is required prior to sample collection

Is your agency tax exempt? If yes, please provide your GST/HST number: _____
(If you do not provide your GST/HST number, tax will be charged)

Does the person paying for the test require a receipt to be mailed to them? ❑ Yes ☐ No

❑ Attached is a copy of the government authorization. The laboratory will automatically send an invoice upon receipt of the last sample in the case.

❑ Payment is included (If a private party is paying, please send a certified cheque or money order payable to Orchid PRO-DNA).

❑ Visa ❑ MasterCard ❑ American Express

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

An administrative fee will apply if this case is cancelled at any time prior to testing.