

DNA PRE-NATAL PATERNITY TESTING APPLICATION (Court Ready)

To initiate a paternity test, please complete this form and fax or mail to Orchid Cellmark.
Results will be completed within 5-7 days from the date of receipt of the samples in our laboratory and will be sent by US Mail.
Please note that the mother's samples must be taken on the same day, or before, the fetal sample.

PARTIES TO BE TESTED		Orchid Cellmark Case #
M O T H E R	Name	
	Address	Date of Birth
	City/State/Zip	Due Date
	Daytime Phone # Evening 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)
		<input type="checkbox"/> CVS <input type="checkbox"/> Amniotic fluid
A L L E G E D F A T H E R	Name	
	Address	Date of Birth
	City/State/Zip	
	Daytime Phone # Evening Phone #	
PHYSICIAN INFORMATION (Please indicate the name of the doctor who will be collecting the pre-natal sample)		
D O C T O R	Name	
	Address	
	City/State/Zip	
	Phone #	
SCHEDULING INFORMATION (Please indicate scheduling preferences in the space below)		
<input type="checkbox"/> Mother and Alleged Father to be tested at the hospital at the same time as the pre-natal sampling <input type="checkbox"/> Mother at hospital / Alleged father at a third party collection site <input type="checkbox"/> Mother and Alleged father at the same third party collection site at the same time <input type="checkbox"/> Mother and Alleged father at separate third party sites		
PAYMENT INFORMATION		
* The price for a prenatal paternity test is \$750 for a mother, fetal sample and alleged father. Each additional alleged father is an additional \$175 * Full payment for services by money order, cashier's check or credit card is required in advance * We can accept Western Union wire transfers too - please call for specific instructions * \$100.00 cancellation fee if cancelled prior to receiving all samples in lab - Cases are non-refundable after 6 months.		
\$	is included (Money order, certified or cashier's check is accepted. Please make payable to Orchid Cellmark)	
\$	may be charged to the following credit card: Visa / MasterCard /Discover /American Express	
Card #:	_____	Expiration: _____ 3 Digit Authorization Code: _____
Name of Card Holder:	_____ Cardholder Signature: _____	
Address of Cardholder if different than person receiving results (we will mail credit card receipt to cardholder):		

INTERNET