



LifeLabs Medical Laboratory Services
 3680 Gilmore Way
 Burnaby BC V5G 4V8
 Tel: 604 412-4535 800 663-9422 ext 4535
 Fax: 604 412-4444 877 412-4440

LifeLabs Case Number (for internal use only): 2009 – –
Date Received (for internal use only):
Results required by (for internal use only):

TEST REQUEST AND PAYMENT FORM FOR DNA PARENTAGE TESTING

Client (Requestor)	Name		
	Phone number including area code	Fax number for result	<input type="checkbox"/> LifeLabs PSC (same as sample collection site) <input type="checkbox"/> Lawyer's Number
Test Type (internal use only)	Address for test results to be mailed to		
<input type="checkbox"/> Legal	Signature of Client (Requestor)		
<input type="checkbox"/> Home			Date

If Client (Requestor) requires collection please complete Patient #1 section.

Patient/Donor #1 Alleged Father Child Mother Other

Last name	First name	Middle initial	Telephone number:	Date of birth (dd-mmm-yy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address					
Indicate sample type <input type="checkbox"/> buccal swab (preferred) <input type="checkbox"/> blood		Preferred collection site		Preferred date & time of appt	

Patient/Donor #2 Alleged Father Child Mother Other

Last name	First name	Middle initial	Telephone number:	Date of birth (dd-mmm-yy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address					
Indicate sample type <input type="checkbox"/> buccal swab (preferred) <input type="checkbox"/> blood		Preferred collection site		Preferred date & time of appt	

Patient/Donor #3 Alleged Father Child Mother Other

Last name	First name	Middle initial	Telephone number:	Date of birth (dd-mmm-yy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address					
Indicate sample type <input type="checkbox"/> buccal swab (preferred) <input type="checkbox"/> blood		Preferred collection site		Preferred date & time of appt	

RUSH RESULTS	Please note that RUSH/STAT Results are available. Additional fees will apply.
Result Reporting	Please indicate if additional copies of the report are required. Patient #1 <input type="checkbox"/> Patient #2 <input type="checkbox"/> Patient #3 <input type="checkbox"/> Please provide contact name and address if different than above.
Additional Report for:	

Payment: (Do NOT Mail Cash) MasterCard Visa Cheque or Money Order (Payable to LifeLabs) GST Exempt (only if referred by Physician)

Credit Card Number	Expiry Date	Amount – plus GST unless exempt \$	Credit Card Authorization # (For internal use only)	Date
Name appearing on Credit Card	Signature of Credit Card Holder		(For internal use only) <input type="checkbox"/> Paid <input type="checkbox"/> Collect Payment	

Payment / Refund:
 Full Payment - required after confirmation of the appointment booking and prior to forwarding the collection kit to the chosen collection site.
 Partial refund payment - \$150.00 (cancellation fee) is not refundable if the appointment is cancelled 24 hours prior to the appointment date and time.
 Non-refundable payment - less than 24 hours notice of the cancellation of the appointment and/or after completion of the collection and testing.

Testing (internal use only) Paternity Maternity Sibling Rel. Other please explain: Home Collection.

For Internal Use Only:		Collection Appointment(s)						
	Location	Date	Time	Appt:	Kit sent	MS DB	E-test	
P1				<input type="checkbox"/> T <input type="checkbox"/> S	<input type="checkbox"/>			
P2				<input type="checkbox"/> T <input type="checkbox"/> S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
P3				<input type="checkbox"/> T <input type="checkbox"/> S	<input type="checkbox"/>			

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