



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):	— —
Date Received (for internal use only):	
Results required by (for internal use only):	

TEST REQUEST AND PAYMENT FORM FOR DNA PARENTAGE TESTING

Client (Requestor) Test Type <input type="checkbox"/> Lab Collection (legal) <input type="checkbox"/> Home (non-legal)	Name	
	Phone number including area code	
	Address for test results to be mailed to	
	Signature of Client (Requestor)	Date

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

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					
Preferred collection site			Preferred date & time of appt		

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					
Preferred collection site			Preferred date & time of appt		

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					
Preferred collection site			Preferred date & time of appt		

Result Reporting	Please indicate if additional copies of the report are required. Donor #1 <input type="checkbox"/> Donor #2 <input type="checkbox"/> Donor #3 <input type="checkbox"/> Please provide contact name and address if different than above.
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Additional Report for:	
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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	HST or GST will be additional	\$	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)	<input type="checkbox"/> Paternity	<input type="checkbox"/> Maternity	<input type="checkbox"/> Sibling Rel.	<input type="checkbox"/> Other please explain:	<input type="checkbox"/> Home Collection.
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For Internal Use Only:		Collection Appointment(s)				
Location	Date & Time	Appt:		Kit sent	Tracking #	Logged
D1		<input type="checkbox"/> T	<input type="checkbox"/> S	<input type="checkbox"/>		<input type="checkbox"/>
D2		<input type="checkbox"/> T	<input type="checkbox"/> S	<input type="checkbox"/>		<input type="checkbox"/>
D3		<input type="checkbox"/> T	<input type="checkbox"/> S	<input type="checkbox"/>		<input type="checkbox"/>

The information contained on this form is confidential and privileged. If the reader is not the intended recipient, any disclosure of this information, distribution or copying is strictly prohibited. If you have received this communication in error, please notify us immediately by telephoning 604 412-4535 or 1-800 663-9422 option 7 for local 4535 Thank you.