Case Reference No: (OFFICE USE ONLY)

AlphaBiolabs
More Care . More Convenience . More Value

DNA Profiling Request Form

Please complete ALL sections in block capitals.

YOUR REFERENCE:		**YOUR CLIENT:**	
QUOTE & PROCEED WITH CASE (✓)	☐	**QUOTE ONLY (✓)**	☐

SECTION 1 - INDIVIDUALS TO BE TESTED

RELATIONSHIP:			
FULL NAME:			
ADDRESS:			
DATE OF BIRTH:			
CONTACT NUMBER : (ESSENTIAL)		DO NOT CONTACT DIRECTLY (✓)	☐

RELATIONSHIP:			
FULL NAME:			
ADDRESS:			
DATE OF BIRTH:			
CONTACT NUMBER : (ESSENTIAL)		DO NOT CONTACT DIRECTLY (✓)	☐

RELATIONSHIP:			
FULL NAME:			
ADDRESS:			
DATE OF BIRTH:			
CONTACT NUMBER : (ESSENTIAL)		DO NOT CONTACT DIRECTLY (✓)	☐

RELATIONSHIP:			
FULL NAME:			
ADDRESS:			
DATE OF BIRTH:			
CONTACT NUMBER : (ESSENTIAL)		DO NOT CONTACT DIRECTLY (✓)	☐

SECTION 2-TESTING REQUIREMENTS

WHAT TYPE OF TEST DO YOU REQUIRE?

PATERNITY ☐	MATERNITY ☐	SIBLING ☐	AUNT/UNCLE ☐	GRANDPARENT ☐	OTHER ☐

ADDITIONAL TESTING REQUIREMENTS:	

FOR PATERNITY/MATERNITY TESTS, COULD A CLOSE RELATIVE OF THE ALLEGED PARENT ALSO POTENTIALLY BE THE BIOLOGICAL PARENT? E.G. THE ALLEGED FATHER'S BROTHER? (if yes it is recommended that this person should also be tested, please provide details on page 1)	YES ☐	NO ☐	
SIBLING TESTS ONLY: Do the test participants share the same mother?	YES ☐	NO ☐	POSSIBLY ☐
SIBLING TESTS ONLY: Do the test participants share the same father?	YES ☐	NO ☐	POSSIBLY ☐

PLEASE STATE WHICH SERVICE YOU REQUIRE
(Times calculated from when all samples are received in to the Laboratory):

Close of Business next working day	☐
Same Day (8 hours - premium fee applies)	☐

DO YOU REQUIRE A STATEMENT OF WITNESS (The standard report is free, there is an additional fee for this Statement)	YES ☐	NO ☐

SECTION 3 – SAMPLE COLLECTION

Please choose your preferred sample collection option:

☐ TO ATTEND ONE OF OUR WALK-IN CENTRES (free sample collection – geographical restrictions apply).

☐ A COMPANY SAMPLE COLLECTOR TO COLLECT THE RELEVENT SAMPLES AT AN ADDRESS OF YOUR CHOICE
(If different from the sample donor's address please enter the details below).

If you would prefer a medical practitioner or GP to collect the samples please provide contact details below.
Note. AlphaBiolabs will charge a fee for the preparation and dispatch of the collection kit. In addition Medical Practitioners/ GPs have the right to charge for their services, for which you will be directly responsible.

SAMPLE DONOR :	
GP NAME:	
ADDRESS:	
CONTACT NUMBER : (ESSENTIAL)	

SAMPLE DONOR :	
GP NAME:	
ADDRESS:	
CONTACT NUMBER : (ESSENTIAL)	

SECTION 4 – ADDITIONAL INFORMATION

IS THE TEST PURSUANT TO A COURT ORDER UNDER S20 OF THE FAMILY LAW REFORM ACT 1969? ESSENTIAL – please attach a copy as your case cannot be progressed without this.	YES ☐	NO ☐
IS THE CHILD(REN) THE SUBJECT OF A CARE ORDER/INTERIM CARE ORDER? ESSENTIAL – please attach an up to date copy as we are unable to arrange sample collection without this.	YES ☐	NO ☐
IS THE CHILD(REN) IN FOSTER CARE? If yes please provide details of social worker/foster parents and person with Parental Responsibility.	YES ☐	NO ☐

NAME:				
ADDRESS:				
CONTACT NUMBER:		DOES THIS PERSON HAVE PARENTAL RESPONSIBILITY?	YES ☐	NO ☐

FILING DATE:		COURT DATE:	

DO YOU REQUIRE SPLIT INVOICING? (if yes, a split invoicing request form will be sent for completion and return)	YES ☐	NO ☐
DO YOU HOLD A PUBLIC FUNDING CERTIFICATE?	YES ☐	NO ☐
WE ALSO OFFER A RANGE OF HAIR STRAND ANALYSIS SERVICES FOR THE DETECTION OF DRUGS AND ALCOHOL. WOULD YOU LIKE FURTHER INFORMATION RELATING TO THESE SERVICES?	YES ☐	NO ☐

ADDITIONAL COMMENTS – Please advise of any information or special requests we should be aware - e.g. Person with Parental Responsibility

.SECTION 5 – INSTRUCTING SOLICITOR/SOCIAL WORKERS DETAILS

FULL NAME:			
COMPANY:			
ADDRESS:			
EMAIL (Essential):			
TELEPHONE (Essential):		FAX:	

SECTION 6 - CONFIRMATION OF AGREEMENT

I/WE HAVE BEEN AUTHORISED BY THE ABOVE PARTIES/COURTS TO INSTRUCT ALPHABIOLABORATORIES LTD TO PERFORM THE TEST REQUIRED IN RELATION TO THE NAMED SAMPLE DONOR(S). I/WE ACCEPT YOUR STANDARD TERMS AND CONDITIONS WHICH ARE INCORPORATED INTO THIS CONTRACT.
IMPORTANT- PLEASE ENSURE THAT AN AUTHORISED FEE EARNER SIGNS THEIR OWN NAME AND NOT THAT OF THE SOLICITOR'S FIRM
(Terms and Conditions can be viewed at www.alphabiolabs.com)

SIGNED:		DATE:	
PRINT NAME:		POSITION HELD:	
PAYMENT DETAILS:			

THE INSTRUCTING LAW FIRM IS ACCOUNTABLE FOR THE FULL AMOUNT OF THE INVOICE.

IT IS THE RESPONSIBILITY OF THE INSTRUCTING LAW FIRM TO SEEK PAYMENT FROM THIRD PARTY SOLICITORS – PLEASE NOTE A STRICT 30 DAY PAYMENT POLICY APPLIES.

IF YOU REQUIRE SPLIT INVOICING PLEASE ENSURE THAT YOU COMPLETE AND RETURN OUR SPLIT INVOICING FORM PRIOR TO THE COMPLETION OF THE CASE.

PLEASE RETURN ANY COMPLETED FORMS BY FAX TO 0845 50 50 002 OR BY EMAIL TO info@alphabiolabs.com