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Case Reference No: (OFFICE USE ONLY)

Immigration DNA Profiling Request Form - Ireland

Please complete ALL relevant sections in block capitals.

YOUR REFERENCE:	YOUR CLIENT:
QUOTE & PROCEED WITH CASE (✓) <input type="checkbox"/>	QUOTE ONLY (✓) <input type="checkbox"/>
SECTION 1 - INDIVIDUALS TO BE TESTED	
RELATIONSHIP:	
FULL NAME:	
ADDRESS:	
DATE OF BIRTH:	
CONTACT NUMBER : (ESSENTIAL)	
RACIAL ORIGIN (Delete as applicable)	Afro-Caribbean/Caucasian/Chinese-Asian/Indian-Asian/Other.....
MEDICAL HISTORY <small>(Please give details of any known genetic diseases or recent infectious diseases)</small>	
RELATIONSHIP:	
FULL NAME:	
ADDRESS:	
DATE OF BIRTH:	
CONTACT NUMBER : (ESSENTIAL)	
RACIAL ORIGIN (Delete as applicable)	Afro-Caribbean/Caucasian/Chinese-Asian/Indian-Asian/Other.....
MEDICAL HISTORY <small>(Please give details of any known genetic diseases or recent infectious diseases)</small>	
RELATIONSHIP:	
FULL NAME:	
ADDRESS:	
DATE OF BIRTH:	
CONTACT NUMBER : (ESSENTIAL)	
RACIAL ORIGIN (Delete as applicable)	Afro-Caribbean/Caucasian/Chinese-Asian/Indian-Asian/Other.....
MEDICAL HISTORY <small>(Please give details of any known genetic diseases or recent infectious diseases)</small>	

Customer Services: Tel: 01 402 9466 E-mail: info@alphabiolabs.ie

Dublin Administraton Office: AlphaBiolabs, Block 4, Harcourt Centre, Harcourt Road, Dublin 2, Ireland

Warrington Laboratory: 14 Webster Court, Carina Park, Warrington. WA5 8WD

RELATIONSHIP:	
FULL NAME:	
ADDRESS:	
DATE OF BIRTH:	
CONTACT NUMBER : (ESSENTIAL)	
RACIAL ORIGIN (Delete as applicable)	Afro-Caribbean/Caucasian/Chinese-Asian/Indian-Asian/Other.....
MEDICAL HISTORY <small>(Please give details of any known genetic diseases or recent infectious diseases)</small>	

RELATIONSHIP:	
FULL NAME:	
ADDRESS:	
DATE OF BIRTH:	
CONTACT NUMBER : (ESSENTIAL)	
RACIAL ORIGIN (Delete as applicable)	Afro-Caribbean/Caucasian/Chinese-Asian/Indian-Asian/Other.....
MEDICAL HISTORY <small>(Please give details of any known genetic diseases or recent infectious diseases)</small>	

SECTION 2 – ADDITIONAL INFORMATION (Please ignore this section if this is a private case i.e. without a solicitor)

Solicitor/Institution

NAME:			
ADDRESS:			
TELEPHONE:		FAX:	
EMAIL:			
CLIENT NAME:			
YOUR REF:			

SECTION 3-TESTING REQUIREMENTS

WHAT TYPE OF TEST DO YOU REQUIRE?

PATERNITY <input type="checkbox"/>	MATERNITY <input type="checkbox"/>	SIBLING <input type="checkbox"/>	AUNT/UNCLE <input type="checkbox"/>	GRANDPARENT <input type="checkbox"/>	OTHER <input type="checkbox"/>
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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 <input type="checkbox"/>	NO <input type="checkbox"/>
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SIBLING TESTS ONLY: Do the test participants share the same mother?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	POSSIBLY <input type="checkbox"/>
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SIBLING TESTS ONLY: Do the test participants share the same father?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	POSSIBLY <input type="checkbox"/>
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PLEASE STATE WHICH SERVICE YOU REQUIRE
(Times calculated from when all samples are received in to the Laboratory)

Close of Business next working day	<input type="checkbox"/>
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Same Day (8 hours - premium fee applies)	<input type="checkbox"/>
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DO YOU REQUIRE A STATEMENT OF WITNESS (The standard report is free, there is an additional fee for this Statement)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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SECTION 4 – SAMPLE COLLECTION

Please provide contact details GP or medical practitioner 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)	

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

Sampling Appointment**(i) Overseas Appointments**

It is the responsibility of the parties overseas to contact either the British High Commission/Embassy to determine whether they are willing to take samples. If so, please provide details of the relevant contact name and address. Alternatively, contact a doctor overseas and advise us of the full name, address and telephone number. We will arrange for a kit to be dispatched directly to the doctor.

(ii) What will happen next?

AlphaBiolabs will send the sampling kits to the doctor(s) or if selected will make arrangements for a company nurse to collect the samples. You then attend the appointment taking with you two passport-sized photographs, one of the accepted identification documents and a photocopy of the identification document.

(iii) Acceptable Document are:

Passport, Home Office Travel Document, Home Office Standard Acknowledgement Form or Application Registration Form bearing a photo of the person concerned, Refugee Travel Document
If you are unable to produce any of these documents please contact AlphaBiolabs on: +44 (0)1925 255450

Sampling Notification Form (To be signed by the authorised party)

If you supply the immigration authorities with copies of your results, AlphaBiolabs may then be contacted by the Entry Clearance Officer or Home Office for duplicate copies of these results and/or identification paperwork to confirm their validity. So that AlphaBiolabs can supply this information, and to avoid and delay in your immigration application, please ensure that you complete the disclosure consent form below. It must be completed and returned to AlphaBiolabs with this registration form.

SECTION 5 – DISCLOSURE CONSENT

I (name in capitals)..... hereby consent to AlphaBiolabs sending to the Entry Clearance Officer or Home Office, without further reference to me, a copy of the report:

	Name	Date of Birth	Relationship (Alleged Father / Mother / Child)
1			
2			
3			
4			
5			
6			

I also consent to the supply to the Entry Clearance Officer or the Home Office, of any photographs or other documentation received by the testing organisation in connection with the test, and to the supply of a report if that should be necessary. I give consent to this on the condition that it will involve no fees or expense on my part, and that the Entry Clearance Officer or Home Office will provide me or my representative with a copy of any request for any further reports obtained from the testing organisation.

Signed:		Date:	
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IMMIGRATION DETAILS

Has entry Clearance already been applied for? Yes No

If "Yes", where was the application made?	
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Was entry clearance refused? Yes No

ECO/Home Office Reference Number:	
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SECTION 6 – REPORT DISTRIBUTION

Two copies of the DNA Test Report are usually made available (additional copies will be subject to an administration fee). Please complete the section below so that the reports can be distributed to the relevant individuals or their solicitors. Reports will only be sent to those listed below.

TO WHOM SHOULD OUR REPORT BE SENT:

1st Report:

NAME:

ADDRESS:

EMAIL:

2nd Report:

NAME:

ADDRESS:

EMAIL:

Do you require the report to be posted to The Home Office via Special Delivery? If so, an additional €14 fee applies

Yes No

Please Note: In the first instance our report will be restricted to the above named person. However, all parties to this case are entitled to receive a copy upon written application to AlphaBiolabs. For each additional test report requested, an administration charge will apply.

SECTION 7 – CONFIRMATION FROM SOLICITOR / SOCIAL WORKER (if applicable)

I/WE HAVE BEEN AUTHORISED BY THE ABOVE PARTY/PARTIES OR THE COURTS TO INSTRUCT ALPHABIOLABS TO PERFORM THE DNA TEST REQUIRED IN RELATION TO THE NAMED CHILD/CHILDREN AND 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.ie)

SIGNED:

DATE:

PRINT NAME:

POSITION HELD:

DO YOU REQUIRE SPLIT INVOICING? Yes No

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

PLEASE RETURN ANY COMPLETED FORMS BY EMAIL TO: info@alphabiolabs.ie