Case Reference No: (OFFICE USE ONLY)

AlphaBiolabs
More Care . More Convenience . More Value

Public Legal DNA Profiling Request Form

Please complete ALL sections in block capitals. Please note by submitting this request you agree to the Terms & Conditions of this test which can be viewed at www.Alphabiolabs.com

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 TESTS IS THE MOTHER PROVIDING A SAMPLE?				YES ☐	NO ☐
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? (additional fees apply)				YES ☐	NO ☐

SECTION 3 – SAMPLE COLLECTION		
DO YOU REQUIRE A COMPANY NURSE TO COLLECT THE RELEVANT SAMPLES? (Court admissible DNA tests require collection by an independent third party. This can be a company nurse or GP who provides this service.)	YES ☐	NO ☐
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 – DETAILS OF PERSON REQUESTING TEST			
FULL NAME:			
ADDRESS:			
EMAIL (Essential):		TELEPHONE (Essential):	
FAX:		PLEASE PROVIDE A PASSWORD TO ENSURE CONFIDENTIALITY	

SECTION 5 – ADDITIONAL INFORMATION			
FILING DATE:		COURT DATE:	
DO YOU REQUIRE A HARD COPY OF THE REPORT? (Additional reports will be charged at £25.00 plus VAT per copy.)	YES ☐	NO ☐	
NAME:			
ADDRESS:			
CONTACT NUMBER			
ADDITIONAL COMMENTS – Please advise of any information or special requests of which we should be aware.			

SECTION 6 – PAYMENT DETAILS			
PLEASE MAKE CHEQUES PAYABLE TO: ALPHA BIOLABS – TERMS AND CONDITIONS APPLY. IF YOU HAVE ORDERED ONLINE OR BY TELEPHONE PLEASE SIGN BELOW. WE REQUIRE A SIGNATURE TO PROCESS YOUR PAYMENT, WE WILL NOT RELEASE YOUR REPORT UNTIL FULL PAYMENT HAS BEEN RECEIVED.			
CREDIT/DEBIT CARD INFORMATION (Please complete ALL sections and sign below)			
CARD TYPE:			
CARD NUMBER:			
START DATE:		EXPIRY DATE:	
ISSUE NUMBER:		SECURITY CODE (3 digit number):	
AMOUNT TO CHARGE:			
NAME AS IT APPEARS ON CARD:			
BILLING ADDRESS:	AS SECTION 4 (✓) ☐	PROVIDED BELOW (✓) ☐	
NAME:			
BILLING ADDRESS:			
I AGREE TO PAY THE ABOVE TOTAL AMOUNT ACCORDING TO THE CARD ISSUER AGREEMENT. I UNDERSTAND THAT A CANCELLATION FEE APPLIES.			
SIGNED:	X.....	DATE:	