

## DT Order Form for Paternity Test

### 1. Client Information

|                         |
|-------------------------|
| Last Name, First Name   |
| Street Address          |
| City, ZIP Code, Country |
| Phone number            |
| Fax number              |
| E-Mail                  |

### 2. Order Details (please check)

|                                                                                                                                  | Costs            |
|----------------------------------------------------------------------------------------------------------------------------------|------------------|
| <b>Paternity Test „DelphiTest Economy“:</b> Analysis of 16 DNA regions                                                           |                  |
| <input type="checkbox"/> Analysis Father/Child                                                                                   | € 185            |
| <input type="checkbox"/> Analysis Father/Mother/Child                                                                            | € 215            |
| <input type="checkbox"/> Additional Persons to be tested _____ (please indicate how many)                                        | € 79 per person  |
| <b>Paternity Test „DelphiTest Basic“:</b> Analysis of at least 16 DNA regions;<br>Guaranteed probability as shown in parenthesis |                  |
| <input type="checkbox"/> Analysis Father/Child (>99,9 %)                                                                         | € 349            |
| <input type="checkbox"/> Analysis Father/Mother/Child (>99,99 %)                                                                 | € 369            |
| <input type="checkbox"/> Additional Persons to be tested _____ (please indicate how many)                                        | € 79 per person  |
| <b>Paternity Test „DelphiTest Premium“:</b> Analysis of at least 27 DNA regions;<br>Guaranteed probability >99.99999 %           |                  |
| <input type="checkbox"/> Analysis Father/Child                                                                                   | € 599            |
| <input type="checkbox"/> Analysis Father/Mother/Child                                                                            | € 639            |
| <input type="checkbox"/> Additional Persons to be tested _____ (please indicate how many)                                        | € 149 per person |

Our prices include all fees and taxes.

### 3. Sample Details

|                                                                                                                                                                  |                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Oral fluid (buccal swabs)                                                                                                               | no additional charge                        |
| <input type="checkbox"/> Blood or non-standard samples (e.g. toothbrush, cigarette butts, chewing gum, hair incl. hair root, drinking glass, coffee spoons etc.) | Additional charge of € 99 per person tested |

### 4. Turnaround

|                                                           |                            |
|-----------------------------------------------------------|----------------------------|
| <input type="checkbox"/> Regular Service                  | no additional charge       |
| <input type="checkbox"/> Express Service -5 business days | Additional charge of € 149 |

We will begin your analysis after we received your samples. If you have an express order - we guarantee your test results within the timeframe you have indicated and paid for. Delays are possible when using non-standard samples, especially if the quality of the samples is not good. If we cannot analyze your sample because of poor quality, you can send a replacement sample once without incurring additional fees. The result can only be sent when the total fee has been paid.

**Total Cost for Your Order:**

|  |
|--|
|  |
|--|

## 5. Persons to be tested

| Person* | Name | Date of Birth<br>(voluntary) | sex                      |                          | Sample details           |                          |
|---------|------|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|         |      |                              | male                     | female                   | oral fluid               | non-standard             |
| Father  |      |                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother  |      |                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child   |      |                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|         |      |                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|         |      |                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|         |      |                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

\* Please indicate relationship for additional persons listed (e.g. child 2, alleged father 2).

## Additional Information\*

Ethnicity of the father:  Caucasian  African  Asian (please check)

\* Please indicate special family relationships (e.g. the children are twins, alleged father has a twin brother, father2 and father1 are related)

## 6. Receiving the Results

Please check how you wish to receive the results. If you check nothing, we will mail the results to the address in section 1.

Mail to address of client in section 1

Do not mail

Mail to a different address as listed here:

Contact me via Phone

Contact me via Telefax

Contact me via E-Mail

We would like to point out that DelphiTest might not be able to determine if the client or a contact person listed in section 6 are in fact authorized to receive the test data. We therefore cannot be held liable. It is the responsibility of the client to ensure that the results are not passed on to third parties.

Your signature is binding and acknowledges that you have read and understood our terms and conditions.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

**Bank account**  
Sparkasse Kufstein  
BLZ 20 50 6  
Konto Nr. 7700-013274

**IBAN:**  
AT982050607700013274  
**BIC/SWIFT:**  
SPKUAT21XXX

**CEO**  
Frank Th. Pfannenschmid, PhD