This form shall be handed the physician who takes the blood sample

PATERNITY ANALYSIS FORM

1. Mother
Full Name:_____
Address: _____
Date of Birth: _____

2. Child
Full Name:_____
Address:_____
Date of Birth/ ID-number:_____

3. Putative Father
Full Name:_____
Address:_____
Date of Birth:_____

Declaration: I agree to have my blood sample taken and to be analysed for the purposes of establishing the family relationships. I have not been transfused with blood, nor have I been injected with a blood product or plasma substitute in the last three months, nor have I received a bone marrow transplant.

Date: Signature:

_____ _____

Sample: (ca. 4 ml EDTA anticoagulated blood)
Physician: signature witnessing identity:_____

The blood sample and this form is required to be sent by the physician as first class mail to the following address:

Rannsóknarstofa í réttarlæknisfræði
Department of Pathology
c/o Ágústa Arnold
Hús 8, LSH við Barónstíg
101 Reykjavík