National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

Tel General Enquiries: 01 716 4401
Web: nvrl.ucd.ie
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ORAL FLUID INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename: | | | | | | | | | | | | | **DOB:** D D M M Y Y Y Y

Surname: | | | | | | | | | | | | | **Sex :** F M

Address:

SPECIMEN DETAILS

Oral Fluid Specimen Date & Time of collection: D D M M Y Y Y Y H H M M

CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy.

Please indicate which investigation is required:

Measles ..... ☐

Rubella ..... ☐

Other If other, please specify_____

Date rash onset: ___/___/_____ (dd/mm/yyy)

Other relevant details (include recent exposure risks/contacts, travel history and dates):

Vaccination History (please complete)

1st MMR Date of vaccination	Yes	No	Unknown	Date vaccinated ___/___/_____
2nd MMR Date of vaccination	Yes	No	Unknown	Date vaccinated ___/___/_____

If case reports history of getting monovalent measles (M) or rubella (R) vaccine, or bivalent (MR) vaccine, ***please specify***
Vaccine type_____ Date vaccinated ___/___/_____

**1. Please note, a testing algorithm will be followed,*
2. And tested for the disease considered most likely, based on the clinical and vaccination details provided,
3. "If necessary this will be followed by further testing for other viral diseases specified".
This form should accompany the specimen sent to NVRL
Measles and Rubella are notifiable diseases under Infections Disease Regs (SI No. 707 of 2003)
If you diagnose or strongly suspect measles or rubella; please contact the Medical Officer of Health (local public health department). Prompt notification allows rapid implementation of public health control measures and prevention of onwards transmission

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date: D D M M Y Y Y Y

Tel:

Surgery Address / Hospital Address/Stamp

N.B. Please note that the sample will not be processed without address of surgery or hospital