**National Virus Reference Laboratory**
**University College Dublin**
**Belfield, Dublin 4**

**Tel General Enquiries: 01 716 4401**
**Web: nvrl.ucd.ie**
**Email: nvrl@ucd.ie**

# ORAL FLUID INVESTIGATION REQUEST FORM

## PATIENT DETAILS

**Forename:**

**Surname:**

**Address:**

**DOB:** D D M M Y Y Y Y

**Sex :** F M

**Hospital Number (Mandatory if available)**

**Hospital Lab Number (Mandatory if available)**

## SPECIMEN DETAILS

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

## Collection Details

**Sample collected by**

**Signature**

## CLINICAL DETAILS

**Clinical details aid the selection of an optimal testing strategy.**

Please indicate which investigation is required:

Measles ..... ☐

Rubella ..... ☐

Mumps ..... ☐

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, Mumps and Rubella are notifiable diseases under Infections Disease Regs (SI No. 707 of 2003)
**If you diagnose or strongly suspect measles, mumps 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