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)

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