



Please write clearly in dark ink

SENDER'S INFORMATION

Postcode

Report to be sent FAO

Contact Phone	Ext
Purchase order number	
Project code	

PATIENT/SOURCE INFORMATION

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> GP Patient	
NHS number	Sex <input type="checkbox"/> male <input type="checkbox"/> female
Surname	Date of birth Age
Forename	Patient's postcode
Hospital number	Patient's HPT
Hospital name (if different from sender's name)	Ward/ clinic name
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Weeks	Ward type

SAMPLE INFORMATION

First sample

Your reference

Sample type

Serum Oral fluid Throat swab Urine
 CSF Plasma Viral isolate cDNA
 Other (please specify)

Date of collection Time

Date sent to PHE

Do you suspect from clinical or lab information that patient is infected with Hazard Group 3 or 4 pathogen?

If yes, give **all** relevant details

Note: If infection with a Hazard Group 4 pathogen is suspected, from clinical information or travel history, **you must** contact Reference Lab **before** sending

Please tick the box if your clinical sample is post mortem

Second sample

Your reference

Sample type

Serum Oral fluid Throat swab Urine
 CSF Plasma Viral isolate cDNA
 Other (please specify)

Date of collection Time

Priority status

TESTS REQUESTED

Measles Investigation
 Mumps Confirmation of infection
 Rubella Immunity screen

If only specific tests required please indicate here

IgG IgM PCR Rub Avidity

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Date of onset

Rash Fever Conjunctivitis
 SSPE Parotid swelling
 Neurological involvement (please specify)
 Other symptoms (please specify)

Contact Date of contact

Vaccination History:

1st MMR date
 2nd MMR date
 No MMR
 Single ME MU RU

OTHER COMMENTS

Including GP details, recent travel history, underlying conditions (if known)