



Measles, Mumps or Rubella

Virus Reference Department
61 Colindale Avenue
London NW9 5HT

Phone +44 (0)20 8327 6017/7887
vrdqueries@ukhsa.gov.uk
www.gov.uk/ukhsa

UKHSA Colindale (VRD)
DX 6530006
Colindale NW

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

Inpatient Outpatient GP Patient

NHS number

Surname

Forename

Hospital number

Hospital name (if different from sender's name)

Pregnant Yes No Unknown Weeks

Sex male female

Date of birth Age

Patient's postcode

Patient's HPT

Ward/ clinic name

Ward type

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

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 UKHSA

Second sample

Your reference

Sample type

Serum Oral fluid Throat swab Urine

CSF Plasma Viral isolate cDNA

Other (please specify)

Date of collection Time

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
*If no onset given IgG only will be performed.

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)