UK Health Security Agency

## Measles, Mumps or Rubella

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Please write clearly in dark ink

Report to be sent FAO   Contact Phone   Fix   Purchase order number   Project code	SENDER'S INFORMATION	
Postcode  PATIENT / SOURCE INFORMATION   Inpatient   Outpatient   GP Patient NHS number   Date of birth   Age   Patient's POT   Patient   GP Patient   NHS number   Date of birth   Age   Patient's POT   Patient   GP Patient   NHS number   Date of birth   Age   Patient's POT   Patient's POT   Hospital number   Hospital number   Ward / clinic name   Hospital number   Ward / clinic name   Hospital number   Ward / clinic name   Pregnant   Ves   No   Unknown Weeks   SAMPLE INFORMATION   Unknown Weeks   SAMPLE INFORMATION   Unknown Weeks   SAMPLE INFORMATION   If yes, give all relevant details   Nove if infection with a Hazard Group 4 pathogen? It yes, give all relevant details   Nove if infection with a Hazard Group 4 pathogen is suspected, from clinical information or travel history, you must contact Reference Lab before sending   Nease tick the box if your clinical sample is post morter   Second sample   Your reference   Your reference   Sample type   Search   Oral fluid   Throat swab   Urine   Senum   Oral fluid   Throat swab   Urine   Serum   Oral fluid   Throat swab   Urine   Senum   Oral fluid   Throat swab   Urine   Serum   Oral fluid   Throat swab   Urine   Date of collection   Time   Date of collection   Time   Date sent to Ukhish   TESTS REQUESTED		Report to be sent FAO
Project code  Patients   Source   Information   Impatient   Outpatient   Outpatient		Contact Phone Ext
PATIENT/SOURCE INFORMATION   Inpatient   Outpatient   OP Patient   NHS number   Sex   male   female   Sumanne   Date of birth   Age   Patient's postcode   Patient's postcode   Patient's INFT   Hospital number   Ward J clinic name   Ward type   Pregnant   Ves   No   Unknown Weeks   SAMPLE INFORMATION   First sample   Do you suspect from clinical or lab information that patient is infected with Hazard Group 3 or 4 pathogen? If I'ves, give a frelevant details   Note: finiection with a Hazard Group 4 pathogen? If I'ves, give a frelevant details   Note: finiection with a Hazard Group 4 pathogen? If I'ves, give a frelevant details   Note: finiection with a Hazard Group 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infection with a Hazard Group 5 or 4 pathogen? If I'ves, give a free infected with Hazard Group 5 or 4 pathogen? I'ves or travel history, you must contact Reference Lab before sending information or 1 pathogen in suspected, from clinical information in result information or 1 pathogen? I'ves or you clinical sample is post nortern		Purchase order number
PATIENT/SOURCE INFORMATION		Project code
PATIENT/SOURCE INFORMATION		
Impatient   Outpatient   CP Patient   NHS number   Date of birth   Age   Patient's postcode   Patient's postcode   Patient's HPT   Hospital number   Ward / clinic name   Ward / per   Hospital name // deferent from sender's name)   Ward type   Pregnant   Yes   No   Unknown Weeks   SAMPLE INFORMATION   Date of with a Hazard Group 3 or 4 pathogen? If tyes, 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 mortern   Second sample   Your reference   Vour reference   Sample type   Garage   Serum   Oral fluid   Throat swab   Urine   CSF   Plasma   Viral isolate   CDNA   CSF   Collection   Time   Date of collectio		
Sex		
Date of birth   Age   Patient's postcode   Patient's postcode   Patient's HPT		Cay Decla Female
Patient's postcode		
Patient's HPT	Surname	
Hospital name (if different from sender's name)  Pregnant	Forename	
Ward type		Patient's HPI
Pregnant   Yes   No   Unknown   Weeks    SAMPLE INFORMATION   If yes, give all relevant details   Note: If infected with Hazard Group 3 or 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 mortern   Second sample   Your reference   Your reference   Sample type   Sample type   Sample type   Serum   Oral fluid   Throat swab   Urine   Date of collection   Time   Date of collection   Serum   Oral fluid   Throat swab   Urine   Date of collection   Time   Date of collection   Serum   Oral fluid   Throat swab   Urine   Oral fluid   Oral fluid   Oral fluid   Oral fluid   O	Hospital number	Ward/ clinic name
If yes, give all relevant details   Note: If infection with a Hazard Group 4 pathogen is suspected, from clinical information or trave history, you must contact Reference lab before sending Please tick the box if your clinical sample is post morter   Second sample	Hospital name (if different from sender's name)	Ward type
If yes, give all relevant details   Note: If infection with a Hazard Group 4 pathogen is suspected, from clinical information or trave history, you must contact Reference lab before sending Please tick the box if your clinical sample is post morter   Second sample	<del>-</del>	Do you suspect from clinical or lab information that patient is
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 morter   Second sample  Your reference  Sample type Serum	SAMPLE INFORMATION	
Please tick the box if your clinical sample is post mortem   Second sample    Your reference   Your reference    Sample type   Sample type   Oral fluid   Throat swab   Urine     Serum   Oral fluid   Throat swab   Urine     CSF   Plasma   Viral isolate   cDNA     Other (please specify)   Other (please specify)     Date of collection   Time     Date sent to UKHSA    TESTS REQUESTED     Measles   Investigation   If only specific tests required please indicate here     Mumps   Confirmation of infection   IgG   IgM   PCR   Rub Avidity     Rubella   Immunity screen    CLINICAL PEIDEMIOLOGICAL INFORMATION   Date of onset     If no onset given IgG only will be performed.     SSPE   Parotid swelling   2nd MMR date     SSPE   Parotid swelling   No MMR     Other symptoms (please specify)   No MMR     Other symptoms (please specify)   Single   ME   MU   RU     Contact   Date of contact     OTHER COMMENTS		, -
Second sample   Your reference   Your reference   Sample type   Sample type   Serum   Oral fluid   Throat swab   Urine   Serum   Oral fluid   Throat swab   Urine   Serum   Oral fluid   Throat swab   Urine   CSF   Plasma   Viral isolate   CDNA   CSF   Plasma   Viral isolate   CDNA   Other (please specify)   Other (please specify)   Date of collection   Time   Date of collection   Date of collection   Time   Date of collection   Dat		information or travel history, <b>you must</b> contact Reference Lab <b>before</b> sending
Your reference   Your reference   Sample type   Sample type   Sample type   Serum   Oral fluid   Throat swab   Urine   Serum   Oral fluid   Throat swab   Urine   Serum   Oral fluid   Throat swab   Urine   CSF   Plasma   Viral isolate   CDNA   CSF   Plasma   Viral isolate   CDNA   CTP   Plasma   Viral isolate   CDNA	First sample	
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Serum Oral fluid		Sample type
Other (please specify)  Date of collection		
Date of collection	☐ CSF ☐ Plasma ☐ Viral isolate ☐ cDNA	☐ CSF ☐ Plasma ☐ Viral isolate ☐ cDNA
Date sent to UKHSA  TESTS REQUESTED    Measles	Other (please specify)	Other (please specify)
TESTS REQUESTED    Measles	Date of collection Time	Date of collection Time
Measles   Investigation   If only specific tests required please indicate here   Mumps   Confirmation of infection   IgG   IgM   PCR   Rub Avidity   Rubella   Immunity screen	Date sent to UKHSA	
Mumps   Confirmation of infection   IgG   IgM   PCR   Rub Avidity     Rubella   Immunity screen     CLINICAL/EPIDEMIOLOGICAL INFORMATION     Date of onset   'If no onset given IgG only will be performed.     Rash   Fever   Conjunctivitis   Ist MMR date     SSPE   Parotid swelling   2nd MMR date     Neurological involvement (please specify)   No MMR     Other symptoms (please specify)   Single   ME   MU   RU     Contact   Date of contact     OTHER COMMENTS	TESTS REQUESTED	
Rubella   Immunity screen  CLINICAL/EPIDEMIOLOGICAL INFORMATION  Date of onset "If no onset given IgG only will be performed.  Rash   Fever   Conjunctivitis   Ist MMR date   SSPE   Parotid swelling   2nd MMR date   Neurological involvement (please specify)   No MMR   Other symptoms (please specify)   Single   ME   MU   RU  OTHER COMMENTS	☐ Measles ☐ Investigation	If only specific tests required please indicate here
CLINICAL/EPIDEMIOLOGICAL INFORMATION  Date of onset "If no onset given IgG only will be performed.  Rash   Fever   Conjunctivitis   Ist MMR date   SSPE   Parotid swelling   2nd MMR date   Neurological involvement (please specify)   No MMR   Other symptoms (please specify)   Single   ME   MU   RU  OTHER COMMENTS	☐ Mumps ☐ Confirmation of infection	☐ IgG ☐ IgM ☐ PCR ☐ Rub Avidity
Date of onset "If no onset given IgG only will be performed.  Rash   Fever   Conjunctivitis   Ist MMR date   SSPE   Parotid swelling   2nd MMR date  Neurological involvement (please specify)   No MMR   Other symptoms (please specify)   Single   ME   MU   RU  Contact   Date of contact  OTHER COMMENTS	Rubella Immunity screen	
"If no onset given IgG only will be performed.  Rash   Fever   Conjunctivitis   Ist MMR date     SSPE   Parotid swelling   2nd MMR date     Neurological involvement (please specify)   No MMR     Other symptoms (please specify)   Single   ME   MU   RU     Contact   Date of contact     OTHER COMMENTS		
SSPE Parotid swelling 2nd MMR date  Neurological involvement (please specify)  Other symptoms (please specify)  Contact Date of contact  OTHER COMMENTS		Vaccination History:
Neurological involvement (please specify)  Other symptoms (please specify)  Contact Date of contact  OTHER COMMENTS		☐ Ist MMR date
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Contact Date of contact  OTHER COMMENTS	Neurological involvement (please specify)	□ No MMR
OTHER COMMENTS	Other symptoms (please specify)	☐ Single ☐ ME ☐ MU ☐ RU
OTHER COMMENTS		
Including GP details, recent travel history, underlying conditions (if known)	OTHER COMMENTS	
	Including GP details, recent travel history, underlying conditions (if kno	wn)