UNIVERSITY OF MISSOURI
Y-90 SIR-TeX MICROSPHERE ADMINISTRATION FORM

<table>
<tr>
<td>
Patient sticker here
To include:

Patient Name
DOB
Hospital ID number

</td>
<td>
PATIENT IDENTIFICATION VERIFIED by (2 required):
☐ Name   ☐ Hospital I.D.
☐ Date of Birth   ☐ Personal Recognition
☐ Photo I.D.
</td>
</tr>
<tr>
<td>
Patient is:
☐ Male
☐ Female, declared not currently pregnant or breastfeeding
</td>
<td>
VERIFY PATIENT IS NOT PREGNANT by:
☐ Declares menstruating, not pregnant, or to be post-menopausal <i>OR</i>
☐ Negative pregnancy Test <i>OR</i>
☐ Rendered sterile, i.e. Hysterectomy, Tubal Ligation, etc., <i>OR</i>
☐ Verify patients' age is ≤ 8 or ≥ 60 years
</td>
</tr>
</table>

RADIOPHARMACEUTICAL PRESCRIPTION:
(To be completed by the Authorized User)

PRE-IMPLANT DOCUMENTATION:

Treatment site: ☐ Right lobe ☐ Left Lobe ☐ Entire liver

Date and Time of Procedure: _____ _____

Radionuclide/Physical Form: **Y-90 SIR-Spheres resin microspheres**

Manufacturer: **Sirtex Wilmington, LLC**

Route of Administration: **Intra-arterial**

Prescribed Activity: _____mCi

OR activity delivered at stasis

% Lung Shunting: _____ %

Maximum Shunting Activity: _____mCi

Is the SIR-Spheres Activity Calculator (SMAC) attached? ☐ Yes ☐ No

Authorized User Signature:

_____ Date: _____

RADIOPHARMACEUTICAL DOSAGE VERIFICATION:

Lot No. _____

Prepared Activity [KK]: _____mCi

Date and time: _____ _____

Is the MUHC SIR-Spheres Y-90 Resin Microspheres Verification Worksheet attached? ☐ Yes ☐ No

Pre-/Post-Administration checks performed by signature:

_____ Date: _____

Note: *SirTex Sir-Spheres package insert contraindications advise a maximum permissible dose limit to the lung due to arterial shunting of 30 Gy.*

POST-IMPLANT:
Note: Revisions must be made, signed, and dated by an AU within 24 hours.

Calculated Activity Delivered to Liver: _____mCi   Date and Time of Delivery: _____ _____

Calculated Activity Outside of the Liver from Shunting: _____mCi   Dose Delivered Due to Shunting: _____Gy **(<30Gy)**

Stasis? ☐ Yes ☐ No   Emerging patient conditions? ☐ Yes ☐ No

Provide explanation: _____

_____

Authorized User Signature:

_____ Date: _____

PATIENT RELEASE:

☐ Patient reading at 1 m is <2.0mR/hr
☐ Post-implant instructions given

Final review by NM (Signature): _____ Date: ___/____/____

RETAIN THIS RECORD FOR 3 YEARS: REQIORED BY 10 CFR 35.2040