UNIVERSITY OF MISSOURI
RADIOPHARMACEUTICAL ADMINISTRATION FORM

This form shall be used for the administration of Therapeutic dosages of Radiopharmaceuticals (***EXCEPT Ra-223 XOFIGO)***, dosages of I-131 Sodium Iodide in excess of 30 µCi, and may be used to document other administrations.

RADIOPHARMACEUTICAL PRESCRIPTION:

NOTE: Do not use for Ra-223 Xofigo

(To be completed by authorized physician)

Patient sticker here

To include:
- Patient Name
- DOB
- Hospital ID number

Procedure: _____

Requesting Physician: _____

Authorizing Physician: _____

Radiopharmaceutical Prescribed: _____

Route of administration: _____ ☐ Capsule ☐ Liquid

Dosage Ordered: _____ mCi

Signature of Authorized Physician:

_____ Date_____

☐ Written instructions provided.
☐ Schedule radiation safety for patient release (if needed).

PRE-ADMINSTRATION

Prior to administering the radiopharmaceutical, the person performing the administration must verify the identity of the patient in the written directive, and that the details of the administration are in accordance with the written directive and approved by Nuclear Medicine consult. The person responsible for the administration of the radiopharmaceutical will complete the form.

PATIENT IDENTIFICATION VERIFIED by (2 required):
☐ Name ☐ Hospital I.D.
☐ Date of Birth ☐ Personal Recognition
☐ Photo I.D.

Patient is:
☐ Male ***OR*** (if MALE stop here)
☐ Female (if FEMALE check a box in both sections below)

If Female:

VERIFY PATIENT IS NOT BREAST FEEDING *by:*
☐ Patient has declared not currently breastfeeding

AND

VERIFY PATIENT IS NOT PREGNANT *by:*
☐ Declares menstruating, not pregnant, or to be post-menopausal ***OR***
☐ Negative pregnancy Test ***OR***
☐ Rendered sterile, i.e. Hysterectomy, Tubal Ligation, etc., ***OR***
☐ Verify patients' age is ≤ 8 or ≥ 60 years

RADIOPHARMACEUTICAL DOSAGE VERIFICATION: *(COMPLETED BY PERSON ADMINISTERING RADIOPHARMACEUTICAL)*

Radiopharmaceutical drug being administered: _____ Radiopharmaceutical Lot Number: _____

Pharmaceutical Company measurement: _____mCi Date: ____/____/____ Time: ____:____

Dose Calibrator measurement: _____mCi

Route of Administration: _____ ☐ Schedule thyroid bioassay for liquid I-131.

Signature of Individual Administering Dose: _____ Date: ____/____/____ Time: ____:____

Comments/Notes: _____

Patient Released by One of the Following Criteria

A		B	C
Nuclear Medicine Technologist Release Criteria			**Radiation Safety Staff or AU Release Criteria**
I-131	< 7 mCi	≥ 7 mCi & < 33 mCi	≥ 33 mCi
Re-186	< 150 mCi	≥ 150 mCi & < 770 mCi	≥ 770 mCi
Sm-153	< 140 mCi	≥ 140 mCi & < 700 mCi	≥ 700 mCi
Y-90	NA	NA	**Released by other criteria only**
☐ **Released by activity administered (written instructions not required)**		☐ **Verify written instructions were provided** ☐ **Released by activity administered**	☐ **Verify written instructions were provided** **PLUS** ☐ **Released by initial dose rate**** **OR** ☐ **Released by other criteria*** **

** (see attached - completed by Radiation Safety staff only) *** (see attached – may be completed by NM AU or Radiation Safety staff (if needed))

Final review by Nuclear Medical Staff (Signature): _____ Date: ___/___/____

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