UNIVERSITY OF MISSOURI
RADIOPHARMACEUTICAL ADMINISTRATION FORM
Ra-223 XOFIGO ONLY

This form shall be used for the administration of Therapeutic dosages of ***Ra-223 XOFIGO*** only

RADIOPHARMACEUTICAL PRESCRIPTION:

Radium-223 XOFIGO

(To be completed by authorized physician)

Patient sticker here

To include:

- Patient Name
- DOB
- Hospital ID number

Procedure: *Radium-223 Xofigo*

Requesting Physician: ____________________

Authorizing Physician: ____________________

Radiopharmaceutical Prescribed: ____________________

Route of administration: *IV Administration*

Dosage Ordered: ____________ μCi

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: *Radium-223 Xofigo* Radiopharmaceutical Lot Number: __________

Pharmaceutical Company measurement: ______________ μCi Date: ___/___/___ Time: ___:___

Dose Calibrator measurement: __________ μCi

Route of Administration: *IV Administration*

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					AU or Radiation Safety Staff Release Criteria
Ra-223 Xofigo	<13 mCi	OR	≥ 13 mCi & <66 mCi	OR	≥ 66 mCi
☐ 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