UW Health
University of Wisconsin Hospital and Clinics

Radiopharmaceutical Therapy Dose Documentation Form
I-131 Sodium Iodide

A. WRITTEN DIRECTIVE:		
Pt Name:	MR#:	Female <or> Male
Date of Birth:	Date/Time of Administration:	Route of Administration:
Radiopharmaceutical (Including Isotope):		Dose in mCi:
Clinical <or> Research Protocol Number:		
Indication:	☐ Patient Meets Criteria for this Radiotherapy	
Prescription for Antiemetic? ☐ NO <or> ☐ YES : Ondansetron ODT 8 mg dissolved on tongue within 2 hours post therapy and every 8 hours, **as needed**, for 2 days after the therapy. • In patients with severe hepatic impairment: max 8 mg daily		
Other therapy treatment within the past year ☐ NO <or> ☐ YES Total estimated exposure to an individual exposed to this other patient from other treatments: _____mrem* *The sum of the exposure dose calculated in section E from all treatments within one calendar year MUST be <500 mrem for patient release		
Signature of Authorized MD	Date & Time	
Verified by (initial): _____	**Nuclear Medicine Technologist administering the dose** **Verify the dosage and ensure written directive is accurate and complete**	

B. PATIENT INFORMATION/EDUCATION VERIFICATION: **NOTE: To be completed by the Authorized User**	
Completed by (initial): _____	Patient identification verified (2 methods used; Name must be 1 of the 2) Name AND Birthdate <OR> MRN#
Completed by (initial): _____	Written radiation safety instructions provided. If the patient will receive I-131, the radiation safety checklist in the "Health Facts for You" has been reviewed with the patient and the specific instructions identified.
Completed by (initial): _____	Negative pregnancy test or excluding clinical condition confirmed with reasonable assurance
Completed by (initial): _____	Patient is not currently breast feeding.
Completed by (initial): _____	Informed consent obtained or verified
Completed by (initial): _____	Authorized User verified written directive with nuclear pharmacy personnel.

C. DOSE PREPARATION DOCUMENTATION: **NOTE: Completed by Nuclear Pharmacy personnel preparing dose and administering Nuclear Medicine Technologist**		
Completed by (initial): _____	Compounding personnel verifies correct computer entry, isotope setting, and activity (10%)	
Dose Assay (mCi) = _____	Assay Date & Time:	
Verified by (initial): _____	Administering Technologist verifies correct computer entry, isotope setting, and activity (10%)	
Dose Assay (mCi) = _____	Assay Date & Time:	

D. I-131 THERAPY PATIENT RELEASE JUSTIFICATION RECORD for Exposure from the Patient
RADIATION DOSE TO AN INDIVIDUAL EXPOSED TO PATIENT MUST BE ≤ 500 mrem
Note: Complete either section 1, 2, 3, OR 4, as applicable.

1. Patient with Thyroid (Assumes 100% whole body retention, dose MUST BE ≤ 33 mCi for patient release):	
mrem	Estimated **maximum** dose to an individual exposed to patient. **(15.15 x administered mCi)** Using Appendix U, Table 14, WisReg 1556, Vol 9.
2. Hyperthyroid Thyroid Therapy (Thyroid uptake < 40% or lower (E*), dose MUST BE ≤ 56 mCi for patient release): *** Assumes 0.125 Occupancy Factor (E), patient lives alone and few visits by family & friends for at least the first 2 days.**	
mrem	Estimated **maximum** dose to an individual exposed to patient. **(8.84 x administered mCi)** Using Appendix U, Equation B-5, WisReg 1556, Vol 9.
3. Patient Post-Thyroidectomy (dose MUST BE ≤ 220 mCi for patient release):	
mrem	Estimated **maximum** dose to an individual exposed to patient. **(2.27 x administered mCi)** Using Appendix U, Equation B-5, WisReg 1556, Vol 9.
4. Patient Specific Calculations (Calculations MUST BE APPROVED by Authorized Physician	
mrem	Estimated **maximum** dose to an individual exposed to patient. **(Must be ≤ 500 mrem for patient release)** **Using patient specific calculations,** Using Appendix U, Equation B-5, WisReg 1556, Vol 9. **(Attach spreadsheet used to aid in the calculation: J:/Nuclear/NuclearPharmacy/NRC & Safety & Dosimetry/I131 Exposure/I-131 Thyroid Cancer Exposure Calculation.xls)**

E. ADMINISTRATION VERIFICATION
NOTE: Completed at the time of treatment by administering technologist

Initial	Patient Verification (2 methods used; Name must be 1 of the 2): Name AND Birthdate <OR> MRN
Initial	Negative pregnancy test or excluding clinical condition confirmed with reasonable assurance.
Initial	Patient released at the time of administration
Initial	Patient is not currently breast feeding.
Initial	Patient administered dose

Administering Personnel
Signature _____ Date_____ Time_____