Written Directive

Patient Name:_____ Patient ID#: _____

Radiopharmaceutical name:_____ Dose:_____mCi

Route of administration if other than I-131: _____

Approved by: _____ Date:_____
Authorized User Signature

Radiopharmaceutical Dose Verification: *To be completed by person preparing therapy dose*

Radiopharmaceutical being administered: _____
Lot number or see attached pharmacy slip: _____
Actual dose from dose calibrator:_____mCi
Calculated percent difference from prescribed dose: _____%
Name and signature of individual administering:_____
Date:_____

If there is any doubt with regard to any aspect of this therapeutic administration or the implementation of this written directive, please contact the authorized user before proceeding.

Patient identified by a minimum of two methods: (Check items which apply)

[ ] Name on nuclear medicine request matches hospital ID bracelet.
[ ] Patient recites correct social security number.
[ ] Patient recites correct Date of Birth.
[ ] Positive identification by relative or legal guardian.
[ ] Positive drivers license identification.
[ ] Other method _____
[ ] Yes [ ] No [ ] N/A Female patient pregnant.
[ ] Yes [ ] No [ ] N/A Female patient nursing.

Name and signature of verifier:_____

Date:_____

Completeness of document verification: I attest that all sections of this form were properly completed prior to the therapeutic radiopharmaceutical administration.

Name (print): _____

Technologist Signature:_____ Date:_____