September 17, 2003

THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 9/18/03.

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-03-041

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region IV staff on this date.

Facility
Utah Valley Regional Medical Center
Provo, Utah
License No.: UT2500129
Utah Agreement State Licensee

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: MEDICAL MISADMINISTRATION

DESCRIPTION: On September 15, 2003, the Utah Division of Radiation Control (the Division) notified NRC's Operations Center of a reported medical radiopharmaceutical misadministration involving iodine-131. The event is a medical misadministration based on Utah's current regulation for the medical use of radioactive material.

On September 15, 2003, Utah Valley Regional Medical Center, an Utah licensee, notified the Division that a 58 year old male patient had been administered 0.6 gigabequerel (15 millicurie) of iodine-131 sodium iodide on August 15, 2003, rather than the prescribed 0.2 gigabequerel (4 millicurie) dose. The patient had a thyroid ablation procedure conducted previously. No additional information is available at this time. The Division and the licensee are continuing to investigate this event.

Region IV received notification of this occurrence from NRC's Operations Center. Region IV has informed OEDO, NMSS, OSTP and the Region's SLO and PAO.

This information has been discussed with the State and is current as of 1:00 p.m. (CDT) on September 16, 2003.

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