Good Samaritan Regional Medical Center

700 East Norwegian Street
Pottsville, PA 17901

Q-8

Fax cover sheet

37-15480-01

03009176

FAX #: 570-621-4183

[redacted]

[redacted]

TO: Shirley Xu / NRC

FAX#: 1-610-337-5269.

FROM: William Reppy, Director, Radiology and Medical Diagnostic Services

DATE: 11/29/04

NUMBER OF PAGES TO FOLLOW: 5

COPY INFORMATION: Requested questions — I have also attached a newly created check list for Therapy patients — as well as revised forms to assist us in insuring compliance.

S. 1 135790

Response to questions from Shirley Xu – NRC

Shirley,

Below is the response to the two questions you posed on November 29, 2004.

1. What test/s were performed on the blood drawn after the P-32 injection?

Blood was drawn 10 minutes after the injection in the Angiography suite. The purpose of the blood draw was to survey the blood to insure that P-32 was not in the blood stream. The blood was survey (by a survey meter) after withdrawal. When activity was identified the blood was discarded.

2. A written directive related to the Iridium 192m shipment of 12/07/01 (attached).

There was no written directive associated with this shipment as the treatment was canceled after the shipment was received. These seeds were not subsequently used on any other patients.

Should have any additional questions please do not hesitate to let me know.

Bill Reppy
11/29/04

READY FOR RETURN 1-7-04

A Leader in Innovative Technology

BEST Industries, Inc.

A Trusted Name in Radiation Therapy

Bill of Lading — Iridium 192 Seeds in Nylon Ribbons

C.07

SHIP TO: Good Samaritan Regional Medical Center

Radiology

700 East Norwegian Street

Pottsville PA 17901

Date of Shipment: 12/07/01 P.O. # 154270

Patient's Name:

Number of Ribbons	Number of Seeds Per Ribbon	Activity on Date of Shipment (mg Raeq) Per Seed	Code	Color
4	4	0.4567	0110D	Red
4	5	0.4567	0110D	White

TOTALS: # Ribbons: 8 # Seeds: 36 mCi of Shipment: 29.43

Regardless of the billing address or name, the recipient of this material is responsible for full payment of this order.

7643 Fullerton Road
Springfield, VA 22153

703-451-2378
800-336-4970

FAX: 703-451-5228
WWW.BEST-MEDICAL.COM

Check list for radiation therapy patients:

Patients name: _____

	Date	Initials
1. Nuclear Medicine notified by nursing staff Of patients scheduled date of arrival (ext. 4058)	_____	_____
2. Upon patients arrival to room nursing staff notifies Nuclear Medicine (ext. 4058)	_____	_____
3. Nursing notifies Nuclear Medicine (ext. 4058) of completion of implantation of radioactive sources.	_____	_____
4. Nuclear Medicine verifies written directive is complete	_____	_____
5. Survey of patients room is completed by Dr. Moylan or Nuclear Medicine staff (on Survey Report Form)	_____	_____
6. Nursing staff notifies Nuclear Medicine upon radioactive source removal (ext. 4058)	_____	_____
7. Post removal survey completed by Dr. Moylan or Nuclear Medicine Staff (recorded on Survey Report Form)	_____	_____
8. Chart audit completed after patient is discharged.	_____	_____

This form should be sent to radiology upon patient discharge.

Patient Identification:

Good Samaritan Regional Medical Center

Radiation Survey Report

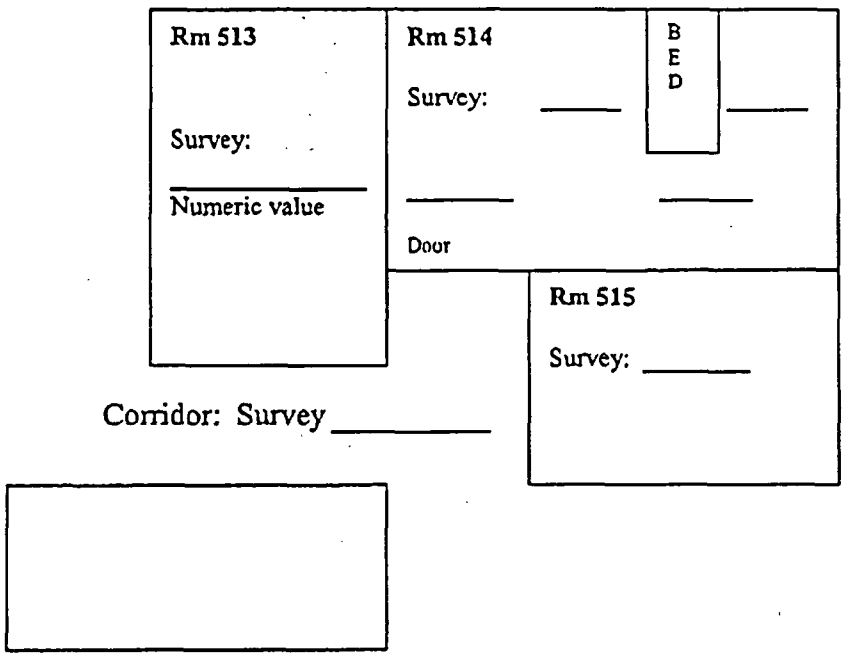
Name of patient: _____ MR #: _____

Treatment with : _____ of _____ on _____
(Amount) (Nuclide) (Date)

Location of patient: _____ (Room #) Nuclide Half Life : _____

Manufacturer/model of meter used for measurement: _____

All readings must be a numeric value from survey meter:



Drawing of vicinity of patient
(Include corridors, adjoining rooms, patient's bed, adjoining beds etc.)

It is unlikely that during the time of treatment any member of the general public will receive a dose greater than 100 mRem.

By: _____

Survey post removal:

Date of Survey: _____ Time: _____ Instrument: _____

Survey results (numeric value): _____ Signed: _____

GOOD SAMARITAN REGIONAL MEDICAL CENTER

Quality Management Plan Treatment Plan (Brachytherapy)

Original Written Directive

Patient Name _____ Date:

History/Diagnosis _____

Procedure _____

Source Type _____

Source Information _____

(# of ribbons/seeds) _____

_____

Total Activity _____

Total Dose Delivered _____

Source placed Date _____ Time _____

Source removed Date _____ Time _____

Time when sources were returned to vault _____

Treatment location/diagram: _____

_____

Patient room monitoring results (numeric value) _____

Radiation Oncologist signature _____

Amended Written Directive (if needed)

Patient Name _____ Date:

History/Diagnosis _____

Procedure _____

Source Type _____

Source Information _____

(# of ribbons/seeds) _____

_____

Total Activity _____

Total Dose Delivered _____

Source placed Date _____ Time _____

Source removed Date _____ Time _____

Time when sources were returned to vault _____

Treatment location/diagram: _____

_____

Patient room monitoring results (numeric value) _____

Radiation Oncologist signature _____

PATIENT IDENTIFICATION

The patient was positively identified by the following two forms of I.D.

Patient Armband Drivers license Sight recognition

S.S. Number Credit Card Other _____