ST. VINCENT HOSPITAL

P O BOX 1221 GREEN BAY, WISCONSIN - 54305 (414) 432-8621



April 8, 1981

Region III Office of Inspection & Enforcement U. S. Nuclear Regulatory Commission 799 Roosevelt Road Glen Ellyn, IL 60137

30-3438

Gentlemen:

In compliance with Title 10, Code of Federal Regulations, Part 35.43, "Reports of Diagnostic Misadministration", St. Vincent Hospital, U.S.N.R.C. License # 48-03220-03, reports the following misadministration for the period January 1, 1981 - March 31, 1981.

Referring Physician: _______, M.D.

Description of Events: The patient, who was to have a bone scan, was injected with Technetium labeled glucohentonate rather than Technetium labeled MDP. Both doses had been drawn earlier and placed in the shielded preparation area. The patient who was to receive the Technetium labeled glucoheptonate did receive the correct radiopharmaceutical as the mistake was discovered immediately.

Effect on Patient: There will probably be no ill effects, short or long term.

Action Taken to Prevent Recurrence: Nuclear Medicine personnel were reminded to draw up doses immediately prior to administration.

Sincerely,

Sister M. Paulette Collings
Executive Vice President

SMPC:nb

cc: Radiation Safety Officer

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