

St. Joseph's Hospital

April 13, 1981

30-3406

United States Regulatory Commission Region III 799 Roosevelt Road Glen Ellyn, Illinois 60137

Dear Sir:

This letter is to inform you that the Nuclear Medicine Section of St. Joseph's Hospital, Milwaukee, Wisconsin, NRC License #48-00537-03 has administered a misadministration of a diagnostic dose of radio-pharmaceutical.

On Monday April 13, 1981, the patient was given an IV injection of 15.0 mCi of Tc-99m MDP. What was ordered was 6.0 mCi of Gallium-67 Citrate.

The referring physician was

John Whitton the radiation safety efficer was notified of the event and an investigation of the occurance resulted. All lables were correct, the dose was identified by the patient's name. The misadministration was the result of inattentativeness by not correctly identifying the patient and the radiopharmaceutical. Recommendations for correction of this problem is to talk to the individual about identifying the patient by their armband and the radiopharmaceutical by the lable on the syringe.

The effect of this misacministration on the patient is considered insignificant.

Sincerely yours,

cc:

John P. Matsis, M. D.

Chairman, Nuclear Medicine

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Nuclear Medicine Radiation Safety Officer

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