

Laboratory of Clinical Medicine
Clinical Pathology
Anatomic Pathology
Nuclear Medicine
Diagnostic Ultrasonography

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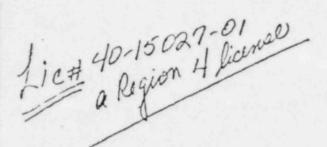
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30-8451

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June 3, 1981

Nuclear Regulatory Commission Region III Office of Inspection and Enforcement 799 Roosevelt Road Glen Ellyn, Illinois 60137

RE: 35.43 Report of Diagnostic Misadministration

Gentlemen:

On 4-9-81 at 1:30 P.M. misadministration of Radiopharmaceutical.

Injection of a diagnostic radiopharmaceutical was injected to the wrong patient, 15 mCi at Tc99m MDP. Requisition slip stated Room 17. Patient was alone in room. Correct patient has been moved and technician didn't check arm band. Technician after talking with patient about symptoms and procedure was convinced had wrong patient.

Referring Doctor, Dr. and the administrator were informed immediately and technician completed a patient incident report. There were no adverse reactions by patient noted immediately or long term.

Immediate corrective action taken. Dr. discussed the incident. Technician was verbally reprimanded and a patient identification procedure was written and instigated.

Sincerely,

Roger M. Rac, Supervisor Mobile Medical Services

RMR: js

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