Yes - 10 CFR 35.33(a)(2) app

IE 12

PUBLIC

UNIVERSAL IMAGING, INC.

MAKING TODAY'S TECHNOLOGY AFFORDABLE

UNIVERSAL IMAGING
12450 Universal Drive
Taylor, MI 48180

(313) 946-4718
FAX: (313) 946-4886

Fixed & Mobile
- CT
- MRI
- Nuclear Medicine

May 16, 1996

21-26532-01
030-33326

Mr. Monte P. Phillips
Chief: Nuclear Materials Safety, Branch 2
United States Nuclear Regulatory Commission
Region III
801 Warrenville Road
Lisle, IL 60532-4351

Reference: **Licensee:** Universal Imaging Inc. at Northwest X-Ray Clinic, 21500 West Eleven Mile Road, Southfield, MI, 48076

The following is a synopsis of the events relating to the misadministration that occurred at the above-referenced location on March 18, 1996:

The dosage in the incident was not prescribed. The RSO, Dr. Wayburn, established the dosage which should have been given for this study.

200 uCi of NaI-131 was given to the patient. The patient should have received NaI-123. Technologist A states that she ordered the standard dosage of 200 uCi NaI-123 plus 100 uCi for this patient. Technologist A believes she ordered NaI-123 and would not have ordered NaI-131; however, NaI-131 was received by Technologist B on the day of the test. Technologist B assumed Technologist A had ordered NaI-131 for a reason and administered 200 uCi NaI-131 to the patient, even though this did not agree with the "Prescribed Dosage List". There was no effect on the patient that Universal Imaging is aware of.

Immediately after Universal Imaging became aware of the misadminstration, the technologist was instructed not to use any radiopharmaceutical that is not on the "Prescribed Dosage List", and never to proceed with any procedure that she is not sure of.

The following steps have been implemented to prevent a recurrence:

1. All technologists have been informed in writing not to use any radiopharmaceutical not listed on the "Prescribed Dosage List".

2. Orders are now sent via facsimile to the radiopharmacy, rather than ordered over the telephone.

3. The radiopharmacy has been instructed not to deliver NaI-131, NaI-125, or any therapeutic radiopharmaceuticals. (Please refer to *Attachment A.*)

050007

4. All technologists have been informed in writing not to proceed if they are unsure of any procedure. (Please refer to *Attachment B.*)

5. Copies of actual activity and radionuclides ordered are checked against receipts.

As per the referring physician's instructions, the patient in the above incident was not notified.

Sincerely,

Mark Lauhoff

Enclosures: 2