Form S

ALABAMA DEPARTMENT OF PUBLIC HEALTH
MEDICAL MISADMINISTRATION REPORT

1. Licensee Name				2. License No.
3. City	**4. State**	**5. Event Date**	**6. Discovery Date**	**7. Report Date**

8. Type of Misadministration

☐Wrong pharmaceutical ☐Dosage differs from prescribed dosage by 50%
☐Wrong patient ☐Wrong route of administration

9. Did the Misadministration Involve Iodine? ☐ Yes ☐ No

10. Number of patients who received misadministrations under this report.

11. Procedure Prescribed	11(a). Dosage Prescribed				12. Dosage Administered			
	Millicuries	Isotope	Chemical form	Study	Millicuries	Isotope	Chemical form	Study
☐ No clinical procedure ☐ Ultrasound study ☐ Nuclear medicine study ☐ CT study (complete **11(a)** and **12.**) ☐ MRI study ☐ X-Ray study ☐ Other								

13. Who or What Precipitated the Misadministration

☐ Nuclear Medicine Physician
☐ Referring Physician
☐ Ward Nurse
☐ Nuclear Pharmacy

_____
Name of Nuclear Pharmacy City State

☐ Hot Lab Technologist
☐ Imaging Technologist
☐ Clinic Receptionist
☐ Scheduling Technologist
☐ Patient
☐ Other

14. Error

Hot Lab		Referral	Administration	Other
☐ Mislabeled a Syringe ☐ Mislabeled a Vial or Vial Shield ☐ Reconstituted Wrong Reagent Kit ☐ Placed Reconstituted Vial in Wrong Shield	☐ Selected Wrong Vial When Drawing Dosage ☐ Set Dose Calibrator Improperly ☐ Misread Dose Calibrator ☐ Misunderstood Radiopharmaceutical or Dosage Order	☐ Misunderstood Referring Physician's Request ☐ Requested Wrong Study ☐ Requested Study for Wrong Patient	☐ Selected Wrong Patient ☐ Requested Wrong Study ☐ Brought Wrong Patient to Clinic ☐ Selected Wrong Syringe From Dosage Cart	☐ Specify _____ _____ _____ _____ _____ _____

15. Contributing Factors		16. Actions Taken to Prevent Recurrence	
☐ Student Technologist ☐ New Employee ☐ Foreign Language ☐ Patient Incoherent or Unconscious ☐ ID Not Checked	☐ Requisition Not Checked ☐ Patient Chart Not Checked ☐ New Procedure ☐ Heavy Workload ☐ Other _____ _____ _____	☐ Implement New Procedures For ☐ Verification of Request ☐ Radiopharmaceutical Labeling and Handling ☐ Verification of Patient ID ☐ Reinstruct Personnel ☐ Reprimand Personnel	☐ Improve Supervision of Personnel ☐ No Action ☐ Other _____ _____ _____ _____

17. Effect on Patient(s)	☐ None Apparent	☐ See Abstract

(Continued on Reverse)

18. Abstract (Include a description of preventative actions taken) Attach additional sheets if necessary.

19. Certification: The undersigned official executing this report on behalf of the licensee named in Item 1, certifies that this report is prepared in conformity with Chapter 420-3-26, and that all information contained herein, including any supplements attached hereto, is true and correct to the best of our knowledge and belief.

Signature of Certifying Official	Printed Name and Title of Certifying Official	Date

For Agency Use Only

Reportable to NRC? ☐ Yes ☐ No	Incident Number:	Reviewed By:

Form S

(Continued on Reverse)