Holy Family Hospital

100 North River Road
Des Plaines, Illinois 60016
(312) 297-1800

October 4, 1984

U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Re: Holy Family Hospital
Lic. No. 12-13614-01

Dear Sir,

In compliance to NRC regulation 10CFR Part 35, "Human uses of by-product materials", we are submitting a report on a misadministration of a diagnostic radiopharmaceutical. The incident occurred as follows:

The patient called the Nuclear Medicine department to request an appointment for a Renogram. The technologist issued the appointment and informed the patient that her physician, Dr. A. Patel, would have to call the department to verify the order before the test could be performed.

When the patient arrived at the hospital, the Out-Patient department called Nuclear Medicine to check if the patient was scheduled. They spoke to the same technologist that scheduled the appointment. He informed Out-Patient department the patient was expected for a Renogram. When the patient arrived in the Nuclear Medicine department, she had a computer order for a Renal Scan and a Venogram. Assuming the Venogram order to be an error, it was changed to a Renogram.

The patient was assisted by two other technologists and was injected with 300uCi I 131 Hippuran and 5mCi Tc99m DTPA. During the Renogram, the technologist became aware that Dr. Patel had not called in the order. We contacted Dr. Patel and was informed by him that he called the X-Ray department and he stated that a contrast Venogram was in fact to be performed.

OCT 9 1984

The patient was informed of the error and was escorted to the X-Ray department for the proper examination. The error occurred due to a lack of understanding between the patient and assumptions by the technologist. To avoid this mishap in the future, a memo was sent to the Medical Staff explaining the problem we have when patients call for appointments without requisitions. We asked for their cooperation in this matter by writing a prescription when possible.

Additionally, all technologists were informed the verbal orders will only be accepted from the physicians or physicians office. With the cooperation of the Medical Staff and the technologist, this type of incident will come to a halt.

Sincerely,

Mariano Marzo, M.D.

Mariano Marzo, M.D.
Radiation Safety Officer

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