## DIAGNOSTIC MISADMINISTRATION REPORT

Address (number, street)       Event date       Report date         City       2/P code       Month       Day       Year         Month       Day       Year       Month       Day       Year         Type of Misadministration       Did the misadministration involve an isotope of iodine?       Number of patients who received a misadministration under this report:       Yes       No         Intended       Intended       Given       Yes       No         Intended       Intended       Given       Study       Misiadministration       Misiadministration         Nuclear method ins tudy (complete "intended"       CT study       Misiadministration       Given       Study       Misiadministration         Precipitator	1							1					
Month       Day       Year       Month       Day       Year         City       ZIP code       Image: Code	Licensee name						Licensee number						
Month       Day       Year       Month       Day       Year         City       ZIP code       Image: Code	Address (number street)						Event date Report date						
City       ZiP code         Type of Misadministration       Dosage differing from prescribed by 50%       Did the misadministration involve an sloope of iodine?       Number of patients who received a misadministration under this report:         Intended       Intended       Intended       Given         Multicular procedure       Ultrasound       Intended       Given         Multicular medicine study (complete "Intended"       C1 study       Multicuries       isotope of iodine?         Multicular medicine study (complete "Intended"       C1 study       Multicuries       isotope of chemical       Study         Precipitator												Maria	
Type of Misadministration       Did the misadministration involve an insadministration under this report:         Wrong radiopharmaceutical       Dosage differing from prescribed by 50%         Wrong radiopharmaceutical       Dosage differing from prescribed by 50%         Intended       Intended         O clinical procedure       Ultrasound         Nuclear medicine study (complete "Intended"       C T study         and "Given" sections)       NMR study         -X-ray study       Other         Precipitator       Authorized user         Ward nurse       Authorized user         Ward clerk       Diditate repations         Name of nuclear pharmacy       City         State       Patient         Misunderstood referring       Selected wrong value whon galue thenhologist         Misunderstood referring       Selected wrong patient         Misunderstood referring       Selected wrong patient         Preceptitied       Set dose calibrator         Improperty       Misunderstood referring         Patient       Misunderstood referring         Patient       Selected wrong patient of dosage calibrator         Prace title       Misunderstood         Precipitated vial in       Misunderstood         Requested study for wrong       Sel	City				ZIP code				vay yea I	ar Mont	n Day	rear	
Wrong radiopharmaceutical       □ Dosage differing from prescribed by 50%       □stope of iodine?       misadministration under this report:         Intended       Wrong patient       Wrong route       Intended       Given         Intended       Intended       Given       Given         No clinical procedure       Ultrasound       Millicurie       leatope       Fermil Study       Millicurie       leatope       Fermil Study         Ant 'Green''s sections)       Other       Other       Intended       Given       Study         Precipitator	City												
Wrong radiopharmaceutical       □ Dosage differing from prescribed by 50%       □sotope of iodine?       misadministration under this report:         Intended       Wrong patient       Wrong route       Intended       Given         Intended       Intended       Given       Given         No clinical procedure       Ultrasound       Multicurie       isotope of pamical study (complete "Intended"       Chemical study         And "Given" sections)       Other       Multicurie       isotope of pamical study       Multicuries       isotope of pamical study         Precipitator													
Wrong radiopharmaceutical       Dosage differing from prescribed by 50%       Yes       No         Intended       Intended       Given         Nuclear medicine study (complete "Intended"       Ultrasound       Milicuries       Isotope       Pomical       Study         Nuclear medicine study (complete "Intended"       Ultrasound       Milicuries       Isotope       Pomical       Study         Nuclear medicine study (complete "Intended"       Other       Precipitator       Imaging technologist       Imaging technologist         Ward nurse       Hot lab technologist       Imaging technologist       Imaging technologist       Imaging technologist         Ward orek       City       State       Other       Patient       Other         Fror       Hot Lab       Referral       Administration       Other         Mislabeled a syringe       Selected wrong vial when drawing dosage       physician's request       Answered waiting room page intended for other page i		on											
Intended       Intended       Given         Intended       Intended       Given         Nuclear medicine study (complete "Intended"       Ultrasound       Isotope       Form       Study         Mulicuries       Isotope       Form       Study       Milicuries       Isotope       Form       Study         Aray study       Other       Other       Imaging technologist       Imaging technologist       Imaging technologist       Imaging technologist         Ward nurse       Imaging technologist       Imaging technologist       Imaging technologist       Imaging technologist       Imaging technologist       Imaging technologist         Nuclear pharmacy       City       State       Patient       Other       Other         Error       Hot Lab       Referral       Administration       Other         Mislabeled a syringe       Grawing dosage       Physician's request       Answered waiting room page intended for other         Mislabeled a vial or vial       Set dose calibrator       Requested twong study for wrong patient       Specify         Patient       Misread dose calibrator       Requested twong study for wrong patient to clinic       Selected wrong syringe from dosage cart       Implement new procedures for:       Implement new procedures for:       Implement new procedures for:       No action	•			prescribed by 50°	%				modami	liotration		report.	
No clinical procedure       Ultrasound       Milicuries       Isotope       Chemical       Study       Milicuries       Isotope       Chemical       Study         No clinical procedure       OT study       Milicuries       Isotope       Chemical       Study	01		Wrong route										
Nuclear medicine study (complete "Intended"       CT study       Millicuries       totope       Form       Study       Millicuries       totope       Form       Study         A'ray study       Other       Other       Image: sections)						Intended			Given				
Indexame inclusion and given sections)       Image of the section of the sections)       Image of the section of the sectin the section of the sectin the section of th	— ·	anlata "I	· · · · · ·		Millicuries	Isotona			Millicuries	Isotone		Study	
X-ray study       Other         Precipitator         Referring physician       Authorized user         Ward nurse       Authorized user         Ward clerk       City         Name of nuclear pharmacy       City         Name of nuclear pharmacy       City         Mislabeled a syringe       Administration         Mislabeled a vial or vial       Selected wrong vial when drawing dosage         shield       Selected wrong study         Placed reconstituted viral in       Misread dose calibrator         more split       Misread dose calibrator         patient       Misread dose calibrator         gradiopharmaceutical or dosage order       Action Taken to Prevent Recurrence         Student technologist       Patient chart not checked       Improve supervision of personnel         New employee       Patient chart not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient chart not checked       Implement new procedures for:       No action         Patient incohrent or unconscious		npiete i			Miniculies	Isotope	1 0111	Olddy	Milliculies	Isotope	ronn	olddy	
Precipitator            Referring physician          Ward nurse          Ward dierk          Ward dierk          Ward oterk          Name of nuclear pharmacy          Name of nuclear pharmacy          Name of nuclear pharmacy          Referring Induction of the technologist          Patient          Other:         Patient          Mislabeled a syringe          Mislabeled a vial or vial          Set dose calibrator          improperly          Requested wrong study          Placed reconstituted wrong          Mislabeled a vial or vial          Set dose calibrator          improperly          reagent kit          Placed reconstituted wrong          Mislabeled a vial or vial          Set dose calibrator          improperly          reagent kit          Placed reconstituted wrong          more subject         Placed reconstituted vial in          Misunderstood          reagent kit          Placed reconstituted vial in          Mi	/			dy									
Referring physician       Authorized user       Hot lab technologist         Ward nurse       Imaging technologist         Ward olerk       City       Scheduling technologist         Nuclear pharmacy       City       State       Patient         Error       City       State       Other         Mislabeled a syringe       Selected wrong vial when drawing dosage       Misunderstood referring physician's request       Answered waiting room page intended for other       Specify         Mislabeled a vial or vial shield       Set dose calibrator       Requested wrong study improperty       Patient       Specify         Placed reconstituted wrong wrong shield       Misread dose calibrator       Requested study for wrong patient       Brought wrong patient to clinic       Selected wrong syringe from dosage cart       Improvervent Recurrence         Student technologist       Patient chart not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient chart not checked       Implement new procedures for:       Other:       Implement new procedures for:         Ib bracelet not checked       Other       Chifcation of patient identification       Other:       Implement new procedures for:       Now action         Ib bracelet not checked       Other       Requistion not checked       Mathonicatina	Precipitator												
Ward nurse       Imaging technologist         Ward clerk       Clinical receptionist         Nuclear pharmacy       Scheduling technologist         Patient       Other:         Error       Mislabeled a syringe       Selected wrong vial when drawing dosage       Misunderstood referring physician's request       Selected wrong patient       Specify         Mislabeled a vial or vial shield       Selected wrong study improperly       Requested study for wrong patient       Selected wrong study patient       Selected wrong syringe from dosage cart       Improverververververververververververververv		Authori	Authorized user			Hot lab technologist							
Nuclear pharmacy       City       Scheduling technologist         Name of nuclear pharmacy       City       State       Patient         Other:       Other:       Other         Error       Mislabeled a syringe       Selected wrong vial when drawing dosage       Misunderstood referring physician's request       Selected wrong patient       Specify         Mislabeled a vial or vial shield       Selected wrong vial when drawing dosage       Requested wrong study improperly       Requested study for wrong patient       Patient on the patient         Placed reconstituted wrong wrong shield       Misunderstood radiopharmaceutical or dosage order       Nisunderstood rodosage order       Patient on the keed         Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient incoherent or unconscious       New procedure       Implement new procedures for:       No action         Patient incoherent or unconscious       Other       Requisition of patient identification       Other:       Other:         Ib bracelet not checked       Other       Reprimand personnel       Reprimand personnel       Other:													
Name of nuclear pharmacy       City       State       Patient         Error <ul> <li>Mislabeled a syringe</li> <li>Selected wrong vial when drawing dosage</li> <li>Shield</li> <li>Set dose calibrator</li> <li>Requested study for wrong patient</li> <li>Brought wrong patient or disage order</li> <li>Misunderstood referring physician's request wrong study</li> <li>Reconstituted wrong reagent kit</li> <li>Misead dose calibrator</li> <li>Placed reconstituted vial in wrong shield</li> <li>Misunderstood radiopharmaceutical or dosage order</li> <li>Student technologist</li> <li>Requisition not checked</li> <li>Implement new procedures for:</li> <li>Improve supervision of personnel</li> <li>New employee</li> <li>Patient nocherent or unconscious</li> <li>Heavy workload</li> <li>Other</li> <li>Weinfication</li> <li>Verification</li> <li>Patient identification</li> <li>Other:</li> <li>New ersonnel</li> <li>Reinstruct personnel</li> <li>Reinstruct personnel</li> <li>Reinstruct personnel</li> <li>Reinstruct personnel</li> <li>Reinstruct personnel</li> <li>Reprimand personnel</li> </ul>													
Error       Other:         Error         Mislabeled a syringe       Selected wrong vial when drawing dosage       Misunderstood referring physician's request       Selected wrong patient       Specify         Mislabeled a vial or vial shield       Set dose calibrator       Requested study for wrong patient       Specify       Specify         Reconstituted wrong reagent kit       Misread dose calibrator       Requested study for wrong patient       Specify       Specify         Placed reconstituted vial in wrong shield       Misread dose calibrator       Requested study for wrong patient       Improve supervision of personnel       Improve supervision of personnel         Student technologist       Requisition not checked       Improve supervision of personnel       Improve supervision of personnel         New employee       Patient chart not checked       Implement new procedures for:       Improve supervision of personnel         Patient incoherent or unconscious       Heavy workload       Other       Other:       Implement identification         Reinstruct personnel       Reinstruct personnel       Reinstruct personnel       Reinstruct personnel       Implement personnel													
Error       Hot Lab       Referral       Administration       Other            Mislabeled a syringe Mislabeled a vial or vial shield         Selected wrong vial when Mislabeled a vial or vial shield         Set dose calibrator improperly         Reconstituted wrong reagent kit         Placed reconstituted vial in wrong shield         Misunderstood readipharmaceutical or dosage order         Selected wrong study for wrong patient         Selected wrong syringe from dosage cart         Selected wrong syringe from dosage	Name of nuclear pharmacy				City								
Hot Lab       Referral       Administration       Other <ul> <li>Mislabeled a syringe</li> <li>Selected wrong vial when drawing dosage</li> <li>Mislabeled a vial or vial shield</li> <li>Set dose calibrator improperly</li> <li>Reconstituted wrong reagent kit</li> <li>Misunderstood wrong shield</li> <li>Misunderstood radiopharmaceutical or dosage order</li> <li>Student technologist</li> <li>Foreign language</li> <li>Patient chart not checked</li> <li>Patient incoherent or unconscious</li> <li>Heavy workload</li> <li>Other</li> </ul> ID bracelet not checked         Other           Other         Ceinstruct personnel           Requisitor of patient incoherent or unconscious         Other           Readiant incoherent or unconscious         Heavy workload           Other         Reprimand personnel           Reinstruct personnel         Reinstruct personnel           Reinstruct personnel         Reinstruct personnel													
Mislabeled a syringe       Selected wrong vial when drawing dosage       Misunderstood referring physician's request       Selected wrong patient       Specify         Mislabeled a vial or vial shield       Set dose calibrator improperly       Requested wrong study       Requested wrong guient       Answered waiting room page intended for other patient         Placed reconstituted vial in wrong shield       Misread dose calibrator indipharmaceutical or dosage order       Misread dose calibrator       Brought wrong patient to clinic         Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient incoherent or unconscious       New procedure       New procedure       No action         ID bracelet not checked       Other       Verification of patient identification       Other       Reginstruct personnel						-							
Mislabeled a vial or vial shield       drawing dosage       physician's request       Answered waiting room page intended for other patient         Reconstituted wrong reagent kit       Misread dose calibrator       Requested study for wrong patient       Brought wrong patient to clinic         Placed reconstituted vial in wrong shield       Misread dose calibrator       Patient       Brought wrong patient to clinic         Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient incoherent or unconscious       New procedure       Radiopharmaceutical labeling and handling       Other:         ID bracelet not checked       Other       Reinstruct personnel       Reinstruct personnel       Other:							-						
shield       Set dose calibrator       Requested wrong study       page intended for other patient         Reconstituted wrong reagent kit       Misread dose calibrator       patient       Brought wrong patient to clinic         Placed reconstituted vial in wrong shield       Misunderstood       radiopharmaceutical or dosage order       Selected wrong syringe from dosage cart       Improve supervision of personnel         Student technologist       Requisition not checked       Improve supervision of personnel       Improve supervision of personnel         New employee       Patient incoherent or unconscious       Heavy workload       Rediopharmaceutical labeling and handling       Other         ID bracelet not checked       Other       Other       Rediopharmaceutical personnel       Recinstruct personnel			v		0					Specify			
Reconstituted wrong reagent kit       improperly Misread dose calibrator       Requested study for wrong patient       patient         Placed reconstituted vial in wrong shield       Misread dose calibrator       Brought wrong patient to clinic       Improperly steent         Selected wrong syringe from dosage order       Requested study for wrong patient       Improperly Brought wrong patient to clinic         Wrong shield       Misread dose calibrator matiopharmaceutical or dosage order       Selected wrong syringe from dosage cart         Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient chart not checked       Verification of request       No action         Patient incoherent or unconscious       Heavy workload       Verification of patient identification       Other:         ID bracelet not checked       Other       Reprimand personnel       Reprimand personnel			0 0					0					
Independent wong       Misread dose calibrator         Placed reconstituted vial in       Misread dose calibrator         Image: student technologist       Misread dose calibrator edose order         Student technologist       Requisition not checked         Image: student incoherent or unconscious       Requisition not checked         Image: student incoherent or unconscious       Mex procedure         Image: student incoherent or unconscious       Heavy workload         Image: student incoherent or unconscious       Heavy more student identification         Image: student incoherent or unconscious       Heavy more student identification         Image: student incoherent or unconscious       Heavy more student identification         Image: student incoherent or unconscious       Heavy more student identification         Image: student incoherent or unconscious       Heavy more student identification         Image: student incoherent or unconscious       Heavy more student identification         Image: student incoherent incoherent or unconscious       Heavy more student identification         Image: student incoherent incoherent incoherent incoherent incoherent identification <td< td=""><td></td><td></td><td colspan="4"></td><td colspan="3"></td><td colspan="4"></td></td<>													
Placed reconstituted vial in wrong shield       Misunderstood radiopharmaceutical or dosage order       clinic		· ·			'			t to					
dosage order       from dosage cart         Contributing Factors       Action Taken to Prevent Recurrence         Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient chart not checked       Verification of request       No action         Patient incoherent or unconscious       New procedure       Radiopharmaceutical labeling and handling       Other:         ID bracelet not checked       Other       Reinstruct personnel       Implement new procedure       Implement new procedures         Reinstruct personnel       Reprimand personnel       Implement new procedure       Implement new procedures       Implement new procedures         Reprimand personnel       Reprimand personnel       Implement new procedures       Implement new procedures       Implement new procedures         Reprimand personnel       Reprimand personnel       Implement new procedures       Implement new procedures       Implement new procedures         Reprimand personnel       Implement new procedures       Reprimand personnel       Implement new procedures       Implement new procedures	Placed reconstituted vial in	understood			-		-						
Contributing Factors       Action Taken to Prevent Recurrence         Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient chart not checked       Verification of request       No action         Poreign language       New procedure       Radiopharmaceutical labeling and handling       Other:         ID bracelet not checked       Other       Verification of patient identification       Implement new procedures for:         Reprimand personnel       New procedure       Requisition not checked       Implement new procedures for:       Implement new procedures for:         Patient incoherent or unconscious       New procedure       Reduipharmaceutical labeling and handling       Other:       Implement new procedures         Reinstruct personnel       Reprimand personnel       Implement new procedures       Implement new procedures	wrong shield		•					0,0	ge				
Student technologist       Requisition not checked       Implement new procedures for:       Improve supervision of personnel         New employee       Patient chart not checked       Verification of request       No action         Poreign language       New procedure       Readiopharmaceutical labeling and handling       Other:         ID bracelet not checked       Other       Reinstruct personnel       Reinstruct personnel			5					0					
New employee       Patient chart not checked       Verification of request       No action         Foreign language       New procedure       Radiopharmaceutical labeling       Other:         ID bracelet not checked       Other       Verification of patient       Image: Chart of patient         ID bracelet not checked       Other       Reinstruct personnel       Image: Chart of patient	5												
Foreign language       New procedure       Radiopharmaceutical labeling and handling       Other:         ID bracelet not checked       Other       Verification of patient identification       Image: Comparison of patient identification         Reinstruct personnel       Reprimand personnel       Reprimand personnel	-		— •		•	•				•	ion of per	sonnel	
Patient incoherent or unconscious       Heavy workload       and handling         ID bracelet not checked       Other       Verification of patient identification         Reinstruct personnel       Reprimand personnel				ecked									
ID bracelet not checked       Other       Verification of patient identification         Reinstruct personnel       Reprimand personnel									_ Other: _				
identification					°				<del></del>				
Reinstruct personnel     Reprimand personnel													
Reprimand personnel													
					Reprimand personnel								
	Effect on Patients												

Attach abstract and mail completed form to:

Compliance Unit California Department of Public Health Radiologic Health Branch, MS 7610 P.O. Box 997414 Sacramento, CA 95899-7414

For more information, go to www.dhs.ca.gov/rhb or phone (916) 327-5106.

Radiation Officer (printed name)	Signature	Telephone number	Date	