Section 2B: Reporting

STANDARD – Radiopharmaceutical Therapy Reporting

2.1B The report of the radiopharmaceutical therapy must be typed or computer-generated and must accurately reflect the treatment performed. This must include:

2.1.1B identification of the name, address and phone number of the facility;

2.1.2B name of the treatment (type of treatment);

2.1.3B patient information:

2.1.3.1B patient's first and last name;

2.1.3.2B gender;

2.1.3.3B date of birth or age; and

2.1.3.4B weight (if applicable).

2.1.4B treating physician's name;

2.1.5B date of the radiopharmaceutical therapy;

2.1.6B the specific radiopharmaceutical administered including:

2.1.6.1B specific identity – radionuclide and chemical form;

2.1.6.2B exact amount administered (XX.X mCi); and

2.1.6.3B route of administration.

2.1.7B the following information must be included in the consult, written directive or final report:

2.1.7.1B requesting health care provider's name;

2.1.7.2B patient's diagnosis and justification for radiopharmaceutical therapy including a summary of relevant clinical history, physical findings, laboratory/pathology results and imaging data;

2.1.7.3B a statement that benefits, alternatives, risks (including side effects) and expected outcomes (including likelihood of success) were discussed with the patient and /or decision maker, and consent was given and documented in writing;

2.1.7.4B statement that the patient was informed of the information above and written consent was obtained;

2.1.7.5B when applicable, evidence that the patient is not pregnant; and

2.1.7.6B when applicable, that the patient is not lactating and/or has been given appropriate breast feeding counseling.

2.1.8B any other relevant procedures that were part of the radiopharmaceutical therapy;

2.1.9B immediate adverse effects of treatment;

2.1.10B any unusual occurrences or variations from clinic protocols; and

2.1.11B report finalization must include:

2.1.11.1B identification and manual or electronic signature (password protected) of the treating, qualified physician;

2.1.11.2B date report finalized and signed by treating physician; and

2.1.11.3B if the report is amended, the original report content, author and date of signature must be retained. The content of the amendment, author and date of amendment must be clearly recorded.