Gleneagles Hospital
HONG KONG
港怡醫院

RAI Prescription and Administration Record

Radiotherapy and Oncology Department

Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Contact No. :	

*(❑ Please ✓ where appropriate   *Delete where inappropriate)   /   RAI – Radioactive Iodine*

Diagnosis: **❑ Graves' Disease ❑ Toxic multinodular goiter ❑ Toxic Adenoma**
❑ Others:_____________________

Treatment: **Radioactive Iodine (I-131) Therapy**

Prescription Dose:	________MBq *(±10% of prescribed activity will be given on administration date)* ❑ Request treatment on / before ______________ *(dd/mm/yyyy)* ❑ *Relapse for thyrotoxicosis for ____times, last RAI administration on ___________ (mm/yyyy)*
Patient Preparation:	❑ Stop seafood ________* days / weeks before treatment. ❑ Stop Anti-thyroid drug ________* days / weeks before treatment. ❑ Start Prophylactic Steroid _______* days / weeks before treatment. ❑ Admission required on date of RAI administration, for _______days Blood test checked: ❑ TFT / ❑ Anti-Tg/ TPO / ❑ RFT / ❑ CBC Repeat blood test before RAI administration ❑ TFT / ❑ others:__________ **For female patient (Age 10 – 60):** LMP: _____________________ *(dd/mm/yyyy)* <Pregnancy Test (urine) will be arranged on RAI administration date> ❑ Post-menopausal / ❑ Hysterectomy done
Follow-up Action:	FU on: _______weeks after RAI therapy / __________________ *(dd/mm/yyyy)* in ❑ Clinic R (GHK) ❑ Doctor's clinic ❑ Other: ______________ Resume Anti-thyroid drugs on _________weeks after treatment / ______________________ *(dd/mm/yyyy)*
Prescribed by:	___________________________________ *Signature and Name* Date: ____________________

RTO Staff's Check:	
I-131 capsule:	❑ Prescription copy sent to MPD by _______________________ *(Signature and Name)*
Remarks:	

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Radioactive Iodine (I-131) Administration Record:

I-131 Activity Measurement:	Measured Date: ______________ (dd/mm/yyyy) ______:______(hh:mm) Measured Activity: ______________
Done by (Physicist):	______________ *Signature and Name*

Pre-intervention Check:	Pregnancy Test : ❑ Not applicable ❑ Test done on: ________ *(dd/mm/yyyy)* ⇨ Result : ❑ Negative ❑ Positive ❑ Patient name and ID ❑ Low iodine diet for 2 weeks ❑ Consent Form signed ❑ No contrast CT 4 weeks ago ❑ Pre-Radiotherapy Assessment done ❑ Stop Anti-thyroid drugs ❑ N.A. ❑ Valid Prescription ❑ Fasting 4 hours ❑ Post-RAI administration precaution explained Sick leave certificate ❑ Given ❑ Not applicable ❑ Post-administration instruction sheet given ❑ FU appointment available, FU on ______________ (*dd/mm/yyyy*)
Checked by:	______________ Date: ______________ *Signature and Name*

Time-out Check:	❑ Patient identity checked ❑ Consent form checked ❑ I-131 dosage (±10% of prescribed activity) checked with prescription
Administration details:	Administration date: ______________ Administration time: ______________ I-131 dosage: ______________ MBq given Remarks: ______________ Radiation Therapist: Counter-check staff:
Given by:	______________ ______________ *Signature and Name* *Signature and Name*

Post-intervention Check:	❑ Documentation completed (HMS- Nurse note & Administration record)
Patient discharge details:	❑ Radiation survey done. Discharge time: ______________ *(hh:mm)*
Checked by:	______________ Date: ______________ *Signature and Name*