



SNMMI CLINICAL – RADIOPHARMACEUTICAL THERAPY CENTERS OF EXCELLENCE

SITE INFO

SITE NAME:

Address:

City:

State:

Zip Code:

LEAD PERSONNEL INFO

NUCLEAR MEDICINE PHYSICIAN:

Name:

Credentials:

Email:

Phone:

Authorized user?

ABNM certified?

ABR-N certified?

NR-CAQ certified?

CBNM certified?

ABR-DR certified?

Other certification:

AUTHORIZED USER (IF DIFFERENT THAN RPT PHYSICIAN):

Name:

Credentials:

Email:

Phone:

ABNM certified?

ABR-N certified?

CBNM certified?

NR-CAQ certified?

ABR-DR certified?

Other certification:

TECHNOLOGIST NAME:

Credentials:

Email:

Phone:

RADIATION SAFETY OFFICER NAME:

Credentials:

Email:

Phone:

Is the RSO part of your team? YES NO

PATIENT/CLINICAL COORDINATOR NAME:

Credentials:

Email:

Phone:

N/A

RADIOPHARMACEUTICAL THERAPY USAGE

For each therapy that you use at your site, enter the number of doses in the past year.

	Number of Annual Therapies		Performed Quantitative Dosimetry Estimates	
	Adult	Pediatric		
Lu-177 dotatate			YES	NO
I-131 radioiodine			YES	NO
Y-90 microspheres			YES	NO
Ra-223 dichloride			YES	NO
I-131 MIBG			YES	NO
Lu-177 PSMA			YES	NO
Other:			YES	NO
Other:			YES	NO
Other:			YES	NO

RADIOPHARMACEUTICAL DISEASE-SPECIFIC TEAMS

THYROID

Endocrinologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do they participate in tumor board with NM and MI specialist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO How often? (e.g. Monthly)
Number of annual therapies:	Number:	
In-patient treatment capability:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Participate in a registry?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

NET

Ability to perform diagnostic RP imaging on site?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Medical oncologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Surgical oncologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Interventional radiologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do they participate in tumor board with NM and MI specialist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO How often? (e.g. Monthly)
Number of annual PRRT therapies:	Number:	
Access to compounded amino acids?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Participate in a registry?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PROSTATE

Ability to perform diagnostic RP imaging on site?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Urologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Medical oncologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Radiation oncologist* participates in care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do they participate in tumor board with NM and MI specialist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO How often? (e.g. Monthly)
Number of annual Ra-223 therapies:	Number:	
Number of annual Lu-177 PSMA therapies:	Number:	
Participate in a registry?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

*Include names of these physicians above.

IMAGING EQUIPMENT ACCESS

PET/CT CAMERA VALIDATED/ACCREDITED BY:

On site?: YES NO

Make:

Model:

Year installed:

PET/CT CAMERA VALIDATED/ACCREDITED BY:

On site?: YES NO

Make:

Model:

Year installed:

SPECT/CT CAMERA VALIDATED/ACCREDITED BY:

On site?: YES NO

Make:

Model:

Year installed:

Quantitation reconstruction package:

SPECT/CT CAMERA VALIDATED/ACCREDITED BY:

On site?: YES NO

Make:

Model:

Year installed:

Quantitation reconstruction package:

DOSE CALIBRATOR:

Make:

Model:

Year installed:

OTHER ONCOLOGY NUCLEAR MEDICINE EQUIPMENT:

Make:

Model:

Year installed:

CONFIRMATION

If designated a Clinical Center of Excellence, you must meet the following criteria. Check if you agree.

Lead Personnel listed above (AU, MI, CNMT) will commit to take 5 hours of CME specifically related to radiopharmaceutical therapy annually and

The department will engage in Quality Improvement Meetings (Part IV MOC) quarterly

I attest that the information presented above is accurate and complete.

Nuclear Medicine Physician Signature:

Authorized User Signature:

Technologist Signature:

Radiation Safety Officer Signature:

Patient/Clinical Coordinator Signature:

Medical Personnel for Consults/Follow-Up Signature:

Date:



Submit forms to Quality@snmmi.org or see snmmi.org/rptcoe for more information.

