

PATIENT INSTRUCTIONS FOLLOWING RADIOACTIVE IODINE TREATMENT

Patient _____ After treatment date _____
UAB MRN _____ Dose _____ mCi Dx _____

You have been given a therapy dose of 131-Iodine. You must follow these radiation safety precautions for ONE WEEK after leaving the Nuclear Medicine Department or Hospital.

- ✓ Avoid close personal contact
 - keep distance to > 3 feet and limit the time to 15-20 minutes /day,
 - no prolonged contact for children under the age of 12 and pregnant individuals,
 - sleep in a separate room / bed for 3 days,
 - Do not nap with children or hold an infant closely
 - Avoid long trips sitting near others (greater than 4 hours)
 - Avoid traveling to public places
- ✓ Sit while urinating and flush the toilet twice, with the lid down after each use. If possible, use a separate bathroom. If this is not possible wipe the toilet seat after each use.
- ✓ Cover you mouth when you cough or sneeze
- ✓ No kissing or sexual intercourse
- ✓ Wash hands frequently.
- ✓ Shower or bathe daily and wash sink or tub after use.
- ✓ Use separate towels and bed linens and launder them separately from others. Also launder underclothing separately.
- ✓ Do not prepare food for others or use gloves when preparing food for others.
- ✓ Do not share food, drink, or eating utensils.
- ✓ Use separate (or disposable) eating utensils for the first few days and wash them separately to reduce the chance of contaminating other family members with radioiodine in your saliva.
- ✓ Use a new toothbrush one week after your treatment.
- ✓ Drink plenty of fluids (at least two quarts of fluid per day), such as water or juices, to help you urinate more frequently. This will help the radioiodine to leave your body more quickly, thus lowering the amount in your body.
- ✓ Keep your saliva flowing with sour balls for several days
- ✓ If vomiting occurs, notify the _____. Carefully clean and discard gastric contents into the toilet.

I understand these instructions and will follow these precautions. A copy has been given to me.

_____ Date _____ UAB# _____
Patient

_____ Date _____
Witness

If you have any questions contact your doctor or call the Endocrine Nurse at _____

Approved by

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