TRI-CITY RADIOLOGY

BODY Imaging Evaluation Form

The following information is necessary to comply with the federally mandated ICD-10 billing requirements, which takes effective Oct. 1st 2015.

NAME:____________________________________ **Age:**_____ **Weight:**_______ **Date:** _________

1. What was your chief complaint when you visited your doctor? ____________________________

2. What is the **specific body part** we are imaging (Abdomen, Pelvis)? ________________________

3. If you have pain; please indicate **where**: ____________________________

   * **How long** has it been hurting? __________________

4. Do you have a **cough**? **YES** or **NO** If yes, for how long? ____________
5. Any recent **weight loss** or **fever**? **YES** or **NO**
6. ANY **surgeries** in the general area (head, neck, chest)? **YES** or **NO** ______________________
7. Are you experiencing **Shortness of breath**? **YES** or **NO** If yes, for how long? _____________
8. Do you have a history of **cancer**? **YES** or **NO** If yes, please list:
   a. Type(s) of cancer: ________________________
   b. Diagnosis date(s): ________________________
   c. Treatments you have completed for it (radiation, chemotherapy): ____

9. **Trauma/injury** involving the area we are imaging today? **YES** or **NO**

   Date of Injury: ____________

   What activity were you doing when you were injured? (skiing, mva, fall) : __________________

   Where did this trauma/injury occur (exact location)? ____________________________

   Please describe the injury: ____

10. Have you had any other imaging tests done on the body part we are imaging today? **YES** or **NO**

    X-Rays? ______________ When & Where? ________________________

    CT Scan? _____________ When & Where? ________________________

    MRI Scan? ____________ When & Where? ________________________

    Bone Scan? ___________ When & Where? ________________________

    Ultrasound?____________ When & Where? ________________________

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CT Patients Only: Have you had recent bloodwork drawn? **YES** or **NO**

If yes, when & where was that done? ____________________________________

Female Patients Only:

Are you pregnant? **YES** or **NO** If No, please give the date of your LMP: _______________

If yes, please notify the technologist immediately!
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