TRI-CITY RADIOLOGY

CAROTID ULTRASOUND 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:** _____

What was your chief complaint when you visited your doctor? _____

_____

Do you have **Diabetes**? **YES** or **NO**

Do you have **High Cholesterol**? **YES** or **NO**

Do you have any **Memory Loss**? **YES** or **NO**

Do you have **High Blood Pressure**? **YES** or **NO**

Do you have any history of **Stroke** or **TIA's**? **YES** or **NO**

Any surgeries in the general area we are imaging today? **YES** or **NO** If yes, please list: _____

_____

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

CT Scan? _____ When & Where? _____

MRI Scan? _____ When & Where? _____

Ultrasound? _____ When & Where? _____