TRI-CITY RADIOLOGY

ORTHOPEDIC 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? _____

   _____

   Specific body part we are imaging? _____ **Right** or **Left?** _____

2. Was there an injury? **YES** or **NO** **Date of Injury**: _____

   Where did this occur? (office, school, skating rink, park)? _____

   List the **specific activity** were you doing, when you were injured: _____

   _____

3. Have you **EVER** had this type of injury on the **same body part**? **YES** or **NO**
   If yes, provide specific details of the prior injury (Date, activity, treatment, diagnosis): _____

   _____

4. Have you ever had surgery and/or arthroscopy on the **SAME** body part that we are imaging today?
   YES or **NO** If yes, provide **place/date** of prior surgery/arthroscopy: _____

   _____

5. Have you had any other imaging tests done on the area we are imaging today? **YES** or **NO**
   X-rays? _____ When & Where? _____
   CT scan? _____ When & Where? _____
   MRI scan? _____ When & Where? _____
   Bone scan? _____ When & Where? _____

6. Do you have **arthritis**?
   If yes, do you have **Osteo / Rheumatoid / Psoriatic arthritis**? **PLEASE CIRCLE ALL THAT APPLY**

   - PLEASE PROVIDE THE **NAME(S)** OF **ALL ARTHRITIS MEDICATIONS** YOU ARE TAKING: _____

   _____

7. Do you have **ANY** history of **cancer**? If yes, please list:
   a. Type(s) of cancer: _____
   b. Diagnosis date(s): _____
   c. Treatments you have completed for it (radiation, chemotherapy): _____

   _____

8. Do you have any other serious medical conditions that we should know about?
   If yes, please provide details: _____