TRI-CITY RADIOLOGY

CT SINUS 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. Have you **ever** had a CT scan of your sinuses before? **YES** or **NO**

   If **yes**, when & where was that performed? ______________________________________

3. Have you previously had any of the following? ***If yes, please describe:***

   a. **Sinus Surgery**? **YES** or **NO**

      If yes, When? __________________ Where? __________________________________

   b. **Brain** or **Neck Surgery**? **YES** or **NO**

      If yes, When? __________________ Where? __________________________________

   c. Do you have a 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): _________________

         ____

   d. **Trauma/injury** involving the head? **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 ____

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Female Patients Only:

Are you pregnant? ________ If no, please give the date of your LMP: ___________________

If YES, please notify the technologist immediately!
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