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(s) we are imaging? ______________________________ **Right** or **Left** (circle)

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

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

   List the **specific activity** you were doing, when the injury occurred: ______________________________

   ____

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 and the procedure: ______________

   ____

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? ______________________________

   How many CT exams **(of <u>ANY</u> body part)** in the last 12 months? ______________________________

   MRI scan? ____________________ When & Where? ______________________________

   Bone scan? ____________________ When & Where? ______________________________

6. Do you have **arthritis?** **YES** or **NO** Type: **Osteo** / **Rheumatoid** / **Psoriatic arthritis** **CIRCLE ALL THAT APPLY**

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

   ____

____

7. Do you have **ANY** history of **cancer**? **YES** or **NO**

   a. Type(s) of cancer & location in the body: ______________________________

   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? **YES** or **NO**

   If yes, please provide details: ______________________________

<u>Female Patients Only</u>: Are you pregnant? _______ *If yes, please notify the technologist immediately!*

Updated 4/2/2018