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? _____

   _____

   Are you currently taking medication for this issue? **YES** or **NO** Type: _____

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

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

   How many CT scans **(of ANY body part)** have you had in the last 12 months? _____

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

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

      If yes, When? _____ Where? _____

      Explain: _____

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

      If yes, When? _____ Where? _____

      Explain: _____

   c. Do you have a history of **cancer**? If yes, please list:

      a. Type(s) of cancer(s): _____
      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: _____

      _____

Female Patients Only: Are you pregnant? _____ *If yes, please notify the technologist immediately!*