TRI-CITY RADIOLOGY

SPINE 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? _____

_____

What is the **specific body part** we are imaging? **Cervical** **Thoracic** **Lumbar** (circle)

2. Was there an injury? **YES** or **NO** **Date of Injury**: _____ **Where** did the injury 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. Do you have **back pain?** **Yes or No** **Extremity pain**? **YES** or **NO** **Where?** _____

Does the pain go down your **arm**? **Yes** or **No** **Right** or **Left** (circle) **Front** or **Back** (circle)

Do you have pain radiating down your **leg**? **Yes** or **No** **Right** or **Left** (circle) **Front** or **Back** (circle)

5. Do you have numbness? **YES** or **NO** Where? _____

6. Do you have weakness? **YES** or **NO** Where? _____

7. Have you had any loss of control of your bladder or bowels? **YES** or **NO**

8. **Have you ever had surgery on the spinal area that we are imaging today**? **YES** or **NO**

When (date)? _____ Facility (location of surgery)? _____

What levels of the spine specifically? _____

What was the short-term (90 days) result of the surgery? _____

If you had some or complete relief, when did the symptoms return? _____

Are the symptoms in the same area as before? **YES** or **NO** Please describe how your problem has changed since the surgery(ies): _____

9. 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 scans **(of <u>ANY</u> body part)** have you had in the last 12 months? _____

MRI scan? _____ When & Where? _____

Bone scan? _____ When & Where? _____

10. Do you have **arthritis?** If yes, do you have **Osteoarthritis** or **Rheumatoid** arthritis? **PLEASE CIRCLE**

11. 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): _____

_____

12. 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!*