TRI-CITY RADIOLOGY

CAROTID ULTRASOUND 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:_____

What was your chief complaint when you visited your doctor? _____

_____

Do you have Diabetes? YES or NO

Do you have High Cholesterol? YES or NO

Do you have any Memory Loss? YES or NO

Do you have High Blood Pressure? YES or NO

Do you have any history of Stroke or TIA's? YES or NO

Any surgeries in the general area we are imaging today? YES or NO If yes, please list: _____

_____

Have you had any other imaging tests done on the body part we are imaging today? YES or NO

CT Scan? _____ When & Where? _____

MRI Scan? _____ When & Where? _____

Ultrasound? _____ When & Where? _____