CT Abdomen and Pelvis Questionnaire **Patient Name:** _____

Medicaid ID #: _____

Contact Name (if additional info is needed): _____

Contact Phone #: _____ **Contract Fax #:** _____

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE:

- DO NOT COMPLETE this questionnaire for Washington Labor and Industries.
- Answer all of the initial questions (Page 1).
- Select the reason for imaging by answering question #4. Based on your answer to question #4, you will be directed to complete ***one*** other section of the questionnaire. Answer ONLY the initial questions and the **ONE** other section as directed based on your answer to question #4.
- Failure to answer ***mandatory*** questions in any part of the questionnaire may lead to technical denial regardless of other answers provided.
- Follow directions exactly. If the question says "select one" answer, only one is needed. Selecting more than one can lead to technical denial.

WARNING FOR WASHINGTON APPLE HEALTH (MEDICAID) REQUESTS: Avoid delays in care by ensuring eligibility *prior to submitting* a request FOR MEDICAID MEMBERS. Before processing the request and sending it to Medicaid, Comagine Health staff will check eligibility in the ProviderOne system. You will be notified if Comagine Health is unable to review due to eligibility.

Initial Questions

1. (**Mandatory**) This guideline based review will result in a RECOMMENDATION ONLY to Washington Medicaid. If the recommendation is to be approved, PLEASE NOTE that services ARE NOT authorized until a final determination is made by the agency.
   - ☐ Acknowledge
2. (**Mandatory**) Has the patient had the same or similar imaging done within the last three (3) months?
   - ☐ Yes What was the date of the most recent imaging? **Date:** _____
   - ☐ No Continue to next question
3. (**Mandatory**) Will you be submitting more than one request for complex imaging for this patient?
   - ☐ Yes (Full review *may* be required for multiple requests. To avoid delays, include chart notes with your request. Records should include history, physical exam, recent imaging reports, and rationale for the imaging being requested.
   - ☐ No Continue to next question
4. Indicate the reason for CT Ab/Pelvis imaging (or organ system that is the subject of imaging): ***Select One***
   - ☐ Abdominal pain, appendicitis, hernia, trauma, or mass – **answer Section A only**
   - ☐ Cancer (any cancer diagnosis) – **answer Section B only**
   - ☐ Kidney (Known or suspected stones, hematuria, infection) – **answer Section C only**
   - ☐ Liver or Gallbladder (includes known or suspected hepatitis) – **answer Section D only**
   - ☐ Pancreas (includes known or suspected pancreatitis) – **answer Section E only**
   - ☐ Gastrointestinal Issues (includes diverticulitis, Crohns and nonspecific GI symptoms) – **answer Section F only**
   - ☐ Abscess/Infection (includes pelvic, tubo-ovarian, PID and fever of unknown origin) – **answer Section G only**

Proceed to the appropriate section (based on your answer above) and answer the questions in ONLY that section.

END of INITIAL QUESTIONS – proceed to complete ONLY one other section.

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION A

CT Abdomen and Pelvis for Pain or Mass

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

INSTRUCTIONAL NOTE: DO NOT USE for kidney-related imaging. If Kidney-related, use Section C.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

1. (Mandatory) Please indicate how pregnancy has been excluded. ***Select one***
   - ☐ Male patient
   - ☐ Sterilization or hysterectomy by history
   - ☐ Pregnancy test (urine or serum HCG) negative
   - ☐ Patient is known or suspected to be pregnant
   - ☐ None of the above

2. Has the patient had an abdominal and/or pelvic CT scan in the last 90 days?
   - ☐ Yes (Full review MAY BE REQUIRED. Submit clinical information for full review with recent history, physical exam, prior imaging reports and rationale for repeat imaging to avoid delays in processing.) – **answer question #3**
   - ☐ No – **skip to question #4**

3. Date of the previous scan: _____

4. Indicate the primary reason for the CT being requested. ***Select one and skip to indicated question***
   - ☐ Acute abdominal pain – **answer question #5**
   - ☐ Appendicitis – **answer questions #6 - 8**
   - ☐ Abdominal mass by exam or ultrasound – **answer questions #9 & 10**
   - ☐ Chronic abdominal pain – **answer questions #11 & 12**
   - ☐ Hernia – **answer question #13**

5. Based on the physical exam and work-up done for this episode of pain. ***Select all that apply***
   - ☐ Abdominal or pelvic tenderness on examination
   - ☐ Urinalysis (UA) normal
   - ☐ Amylase OR lipase normal
   - ☐ Liver function tests (LFTs) normal
   - ☐ No lab results available
   - ☐ Pelvic exam not diagnostic for etiology of pain OR patient is male
   - ☐ None of the above

6. For Appendicitis, indicate which of the following are present on physical exam. ***Select one***
   - ☐ Periumbilical pain
   - ☐ Suprapubic pain
   - ☐ Right lower quadrant (RLQ) pain
   - ☐ Generalized lower abdominal pain
   - ☐ None of the above

7. Which of the following are documented as part of the work-up for appendicitis? ***Select one***
   - ☐ Involuntary guarding with localization pain
   - ☐ Persistent tenderness to direct palpation
   - ☐ Generalized lower abdominal pain
   - ☐ Abdominal rigidity
   - ☐ White blood cell (WBC) or C-reactive protein (CRP) above normal
   - ☐ Temperature above 100.4 F (38.0 C)
   - ☐ None of the above

8. Which of the following are documented as part of the pelvic examination findings? ***Select one***
   - ☐ Male patient
   - ☐ Pelvic exam was diagnostic for the etiology of pain
   - ☐ Patient has had total abdominal hyst with bilateral salpingoopherectomy
   - ☐ Pelvic examination was not done
   - ☐ Pelvic examination was refused
   - ☐ None of the above

9. Indicate how the abdominal or pelvic mass was diagnosed. ***Select one***
   - ☐ Physical exam
   - ☐ Ultrasound
   - ☐ Abdominal x-ray/KUB
   - ☐ CT Scan
   - ☐ None of the above

10. Select the statement which best describes the mass for which imaging is being requested. ***Select one***
    - ☐ Newly diagnosed, no prior CT scan has been done
    - ☐ Follow up imaging, one or more prior CT scan(s) done more than 3 months ago **– answer question 10a**.
    - ☐ Unknown if or when prior CT scan has been done
    - ☐ None of the above

10a. **Date of the most recent CT scan:** _____

11. How long has the patient had abdominal pain? ***Select one***
    - ☐ Less than three (3) months (For pain present less than 3 months, please complete the acute abdominal section.)
    - ☐ More than three (3) but less than six (6) months
    - ☐ Six (6) months or longer
    - ☐ Unknown

12. Which of the following are documented in the medical record as part of the work-up for chronic abdominal pain? ***Select all that apply***
    - ☐ History and physical exam did not identify etiology of pain
    - ☐ Urinalysis (UA) or urine culture negative
    - ☐ Fecal occult blood test (FOBT) negative
    - ☐ No labs done
    - ☐ None of the above

13. Indicate which type of hernia imaging is being requested. ***Select one, then answer the next question as indicated****.* NOTE: This is ONLY for known or suspected hernia. For abdominal mass or any other indication, select a more appropriate indication in question #4.
    - ☐ Ventral, incisional, or epigastric hernia. **Next answer question #13a**
    - ☐ Inguinal or femoral hernia. **Next answer question #13b**

13a. Which of the following statement best describes the clinical plan for the patient? ***Select one***
    - ☐ Treatment/surgical plan will be based on imaging findings
    - ☐ Surgery is not planned at this time
    - ☐ Surgeon will evaluate patient after imaging is done
    - ☐ None of the above

13b. Indicate which of the following is documented in the physical exam. ***Select one***
    - ☐ Groin/lower abdominal or pelvic pain
    - ☐ Intermittent groin swelling or bulging
    - ☐ Physical exam not diagnostic/definitive for inguinal or femoral hernia
    - ☐ Physical exam not done or refused
    - ☐ None of the above

END SECTION A – CT Abdomen and Pelvis for Pain or Mass

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION B

CT Abdomen and Pelvis for Cancer Staging or Restaging

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Indicate the primary reason for the **cancer** imaging being requested. ***Select one***

   ☐ Initial staging – **answer question #2**
   ☐ Follow up after treatment – **answer question #3**
   ☐ New or worsening symptoms or findings – **answer question #6**

2. Has the patient had any prior abdominal and/or pelvic CT scans for initial staging? ***Select one***

   ☐ Yes – **answer question #2a**
   ☐ No
   ☐ Unknown

2a. What type of other imaging has been done?

   ☐ Ultrasound
   ☐ CT Scan
   ☐ PET Scan
   ☐ Unknown

3. Indicate which of the following is the primary reason for restaging CT scan(s). ***Select one***

   ☐ After surgery and before adjuvant chemo/radiation
   ☐ Restaging after initial treatment complete
   ☐ Restaging during treatment – **answer question #4**
   ☐ Surveillance – **answer question #5**
   ☐ After treatment for metastatic or unresectable disease
   ☐ None of the above

4. How many cycles of chemotherapy have been completed since the last imaging? ***Select one***

   ☐ Zero
   ☐ One
   ☐ Two
   ☐ Three or more
   ☐ Only receiving radiation therapy
   ☐ Unknown

5. Surveillance imaging REQUIRES full clinical review. Submit clinical information. Required records are MOST RECENT history, exam, lab results and prior imaging results. Failure to submit records will result in a technical denial. Indicate how records will be provided. ***Select one***

- ☐ Attaching documents (preferred)
- ☐ Faxing to Comagine Health at 888-213-7513

6. Which one of the following symptom or finding is the main reason for the imaging being requested? ***Select one***

- ☐ Anorexia and/or weight loss
- ☐ Abdominal or pelvic pain
- ☐ Abdominal or pelvic mass (new or enlarging)
- ☐ Ascites or hepatomegaly
- ☐ Elevated or increasing lab values
- ☐ None of the above

7. Indicate which lab value or tumor marker is the reason for imaging at this time: ***Select one***

- ☐ Liver function tests (LFT)
- ☐ CA-125
- ☐ CEA
- ☐ None of the above

END SECTION B – CT Abdomen and Pelvis for Cancer Staging or Restaging

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION C

CT Abdomen and Pelvis for Kidney/Hematuria

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Please indicate the primary reason for the **kidney or hematuria** imaging being requested. ***Select one***

   ☐ Hematuria – **answer question #2**
   ☐ Known or suspected kidney stones – **answer question #7**
   ☐ Renal mass by ultrasound – **answer questions #9 & 10**

2. Select the specific indication for imaging in a patient with hematuria. ***Select one.***

   ☐ Gross hematuria – **answer question #2a**
   ☐ Microscopic hematuria – **skip to questions #3 & 4**
   ☐ Follow-up study for gross hematuria where previous CT and cystoscopy have been nondiagnostic for the etiology of hematuria – **skip to questions #5 & 6**

2a. Indicate which of the following are documented in the work-up for gross hematuria. ***Select all that apply***

   ☐ Blood by urine dipstick
   ☐ Dipstick not done
   ☐ Urine culture negative
   ☐ Urine culture results pending
   ☐ Urine culture not done
   ☐ None of the above

3. Indicate which of the following are documented in the work-up for microscopic hematuria. ***Select all that apply***

   ☐ Three (3) or more RBCs per HPF (high powered field)
   ☐ No RBC casts by UA (urinalysis)
   ☐ Blood by urine dipstick (Go back to question #2 and select "Gross hematuria" if blood is present on urine dipstick.)
   ☐ UA results pending
   ☐ None of the above

4. Indicate how a urinary tract infection has been excluded. ***Select one***

   ☐ Urine dipstick or UA negative for nitrite or leukocyte esterase
   ☐ Urine culture negative
   ☐ Urine culture results pending
   ☐ None of the above

5. Has urine cytology testing been completed? ***Select one***

- ☐ Yes
- ☐ No

6. When was the initial workup for gross hematuria started? ***Select one***

- ☐ Within the last six (6) months
- ☐ More than six (6) months
- ☐ Unknown

7. Indicate which one of the following is the main reason for imaging in a patient with known kidney stones. ***Select one***

- ☐ Pain or nausea or vomiting uncontrolled by medications
- ☐ Continued flank or abdominal pain for three (3) or more days
- ☐ Hydronephrosis by imaging – **answer questions #7a & 7b**
- ☐ Continued microscopic hematuria for four (4) or more weeks – **skip to question #8**
- ☐ Stone present by imaging for eight (8) or more weeks
- ☐ None of the above

7a. What type of imaging was used to diagnose hydronephrosis? ***Select one***

- ☐ Ultrasound
- ☐ X-ray
- ☐ CT Scan
- ☐ MRI
- ☐ Unknown
- ☐ None of the above

7b. What was the approximate date of the imaging that diagnosed hydronephrosis?

Date: _____

8. Indicate testing done to confirm presence of hematuria for four (4) or more weeks. ***Select one***

- ☐ Urine dipstick
- ☐ Urinalysis
- ☐ Urine culture
- ☐ Unknown
- ☐ None of the above

9. What type of mass is present on the ultrasound? ***Select one***

- ☐ Complex cystic mass
- ☐ Indeterminate mass
- ☐ Solid parenchymal mass
- ☐ Unknown
- ☐ None of the above

10. Has there been a prior CT scan or MRI to evaluate the renal mass? ***Select one***

- ☐ Yes - Full review MAY BE REQUIRED. Submit clinical information with recent history, physical exam, prior imaging reports, and rationale for repeat imaging to avoid delays in processing.
- ☐ No

END SECTION C – CT Abdomen and Pelvis for Kidney/Hematuria

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION D

CT Abdomen and Pelvis for Liver/Gallbladder

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Please indicate the primary reason for the **liver or gallbladder** imaging being requested. ***Select one***
   - ☐ Liver mass – **answer question #2**
   - ☐ Follow up for liver mass – **answer question #3**
   - ☐ Jaundice – **answer questions #4 & 5**
   - ☐ Hepatocellular cancer or screening/surveillance with known hepatitis – **answer question #8**
   - ☐ Liver transplant work-up in progress – **answer question #9**
   - ☐ Gallbladder imaging – **answer question #10**

2. Select the statement that best describes the liver mass for which imaging is being requested: ***Select one***
   - ☐ Newly discovered by physical exam
   - ☐ Newly discovered by ultrasound, no prior CT scans
   - ☐ CT scan for periodic assessment of known liver mass
   - ☐ None of the above

3. Follow up imaging for known liver mass REQUIRES a full clinical review. Required records are MOST RECENT history, exam, lab results and prior imaging results along with clinical rationale for CT scan. Failure to submit records will result in a technical denial. Indicate how records will be provided. ***Select one***
   - ☐ Attaching documents (preferred)
   - ☐ Fax to Comagine Health at 888-213-7513

4. Indicate which of the following are documented in the work-up for jaundice. ***Select all that apply***
   - ☐ Total bilirubin greater than normal
   - ☐ Alkaline phosphatase greater than normal
   - ☐ Other liver function tests abnormal
   - ☐ None of the above

5. Has ultrasound been done to evaluate cause of jaundice? ***Select one***
   - ☐ Yes - **answer questions #6 & 7**
   - ☐ No
   - ☐ Unknown

6. Enter the approximate date of the ultrasound: _____

7. Did the ultrasound reveal a cause for the jaundice? ***Select one***
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

8. Indicate which of the following is the reason for the imaging being requested. ***Select one***
   - ☐ Hepatitis without cirrhosis
   - ☐ Hemochromatosis with or without cirrhosis
   - ☐ High risk for liver disease due to alcohol or drug use
   - ☐ Primary biliary cirrhosis
   - ☐ Known liver mass, surveillance imaging to evaluate for cancer
   - ☐ None of the above

9. Imaging for a transplant work-up REQUIRES a full clinical review. Required records are MOST RECENT history, exam, lab results, and prior imaging results. Failure to submit records will result in a technical denial. Indicate how records will be provided. ***Select one***
   - ☐ Attaching documents (preferred)
   - ☐ Fax to Comagine Health at 888-213-7513

10. Indicate which of the following gallbladder conditions is the primary reason for the imaging being requested. ***Select one***
    - ☐ Gallbladder wall is calcified on plain x-ray
    - ☐ Cancer of the gallbladder is suspected by ultrasound
    - ☐ Gallbladder mucosal wall tumor is suspected by ultrasound
    - ☐ Post-transplant biliary stricture suspected – **answer question #11**
    - ☐ Sclerosing cholangitis suspected
    - ☐ None of the above

11. Which of the following are documented in the record as part of the work-up for biliary stricture? ***Select one***
    - ☐ Abdominal pain by history
    - ☐ Jaundice by history or physical exam
    - ☐ Abnormal LFTs
    - ☐ None of the above

END SECTION D – CT Abdomen and Pelvis for Liver/Gallbladder

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION E

CT Abdomen and Pelvis for Pancreas

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Please indicate the primary reason for the **pancreas** imaging being requested. ***Select one.***
   - ☐ Suspected acute pancreatitis – **answer questions #2, 3, & 4**
   - ☐ Continued acute pancreatitis after treatment – **answer questions #6, 7, 8, & 9**
   - ☐ Pancreatic pseudocyst – **answer question #10**

2. Does the patient have abdominal pain or tenderness on exam? ***Select one***
   - ☐ Yes
   - ☐ No

3. Indicate which of the following are documented in the record as part of the work-up for acute pancreatitis. ***Select one***
   - ☐ Amylase more than 3 times the upper limit of normal
   - ☐ Lipase more than 3 times the upper limit of normal
   - ☐ Lab results are pending
   - ☐ Labs have not been done
   - ☐ None of the above

4. How long had symptoms been present when work-up was done? ***Select one***
   - ☐ Less than 48 hours
   - ☐ 48 hours or more
   - ☐ Unknown

5. Has an ultrasound been done? ***Select one***
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

6. Is the patient having at least one of the following symptoms despite treatment? ***Select one***
   - ☐ Abdominal pain
   - ☐ Vomiting with attempted oral intake
   - ☐ None of the above

7. Which of the following is documented in the work-up done for continued symptoms despite treatment? ***Select one***

- ☐ Amylase greater than normal
- ☐ Lipase greater than normal
- ☐ Other labs abnormal
- ☐ None of the above

8. Which of the following have been part of the treatment for acute pancreatitis? ***Select all that apply***

- ☐ Enteral or parenteral nutrition
- ☐ Pain medication
- ☐ IV fluids
- ☐ None of the above

9. How long has the patient received treatments for acute pancreatitis? ***Select one***

- ☐ 1 to 4 days
- ☐ 5 to 10 days
- ☐ More than 10 days

10. Imaging for a pancreatic pseudocyst REQUIRES a full clinical review. Submit clinical information. Required records are MOST RECENT history, exam, lab results and prior imaging results. Failure to submit records will result in a technical denial. Indicate how records will be provided. ***Select one***

- ☐ Attaching documents (preferred)
- ☐ Fax to Comagine Health at 888-213-7513

END SECTION E – CT Abdomen and Pelvis for Pancreas

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION F

CT Abdomen and Pelvis for Gastrointestinal

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Please indicate the primary reason for the gastrointestinal imaging being requested. ***Select one***
   - ☐ Suspected diverticulitis – **answer question #2**
   - ☐ Follow up for diverticulitis – **answer questions #3, 4, & 5**
   - ☐ New onset or change in nonspecific GI symptoms (e.g., weight loss, bloating) – **answer question #6**
   - ☐ Crohns disease (known or suspected) – **answer question #7**

2. Indicate which of the following are documented in the work-up for suspected diverticulitis? ***Select all that apply***
   - ☐ Lower abdominal pain/tenderness on exam
   - ☐ Temperature greater than 100.4 F (38.0 C)
   - ☐ White blood cell (WBC) count greater than normal
   - ☐ Diverticulosis by prior imaging study
   - ☐ None of the above

3. Indicate what treatment has been completed after diverticulitis was diagnosed. ***Select all that apply***
   - ☐ Antibiotics for 2 or more days
   - ☐ Nothing by mouth OR clear liquids AND IV fluids 2 or more days
   - ☐ Adjusted dietary intake as tolerated
   - ☐ None of the above

4. Indicate which of the following is documented in the re-evaluation after treatment for diverticulitis. ***Select one***
   - ☐ Temperature above 100.4 F (38.0 C)
   - ☐ White blood cell (WBC) count greater than normal
   - ☐ None of the above

5. Is the patient still having abdominal pain or tenderness after treatment for diverticulitis? ***Select one***
   - ☐ Yes
   - ☐ No
   - ☐ Repeat exam not yet completed
   - ☐ Unknown

6. Indicate which of the following are documented as part of the work-up for nonspecific GI symptoms. ***Select all that apply***

- ☐ Age 45 or greater
- ☐ Fecal occult blood test (FOBT) negative
- ☐ FOBT results pending
- ☐ FOBT not done
- ☐ None of the above

7. Imaging for Crohns disease, whether known or suspected, REQUIRES a full clinical review. Submit clinical information. Required records are MOST RECENT history, physical exam, prior lab and radiology reports and practitioner note indicating reason for requested imaging. Failure to submit records will result in a technical denial. Indicate how record will be provided. ***Select one***

- ☐ Attaching documents (preferred)
- ☐ Fax to Comagine Health at 888-213-7513

END SECTION F – CT Abdomen and Pelvis for Gastrointestinal

Patient Name: _____ **Insurance ID #:** _____

CT Abdomen and Pelvis Questionnaire - SECTION G

CT Abdomen and Pelvis for Abscess, Infection, or Fever

NOTE: Read the questions and responses carefully. If the answer says, "Select One", selecting more than one answer can lead to technical denial regardless of how other questions are answered.

(**Mandatory**) **DISCLAIMER**: I understand that the answers marked on this questionnaire must be supported by the medical records.

☐ Acknowledge

NOTE: After answering question #1, you will be directed to other questions within this section. Please answer only the questions referred to based on your response to question #1.

1. Select the primary reason for the CT request. ***Select one***
   - ☐ Fever of unknown origin – **answer question #2**
   - ☐ Suspected intra-abdominal or pelvic abscess – **answer question #3**
   - ☐ Follow-up of known abscess after treatment – **answer question #4**
   - ☐ Suspected pelvic inflammatory disease (PID) or tubo-ovarian abscess – **answer questions #5 - 8**

2. Indicate which of the following are documented in the record as part of the work-up for the fever of unknown origin. ***Select all that apply***

   - ☐ Temperature above 100.4 F (38.0 C) continuously or intermittent for at least 3 weeks
   - ☐ Fever source not identified by history and physical exam
   - ☐ Blood cultures negative
   - ☐ Urine culture negative OR not diagnostic for etiology of fever
   - ☐ Laboratory studies negative for etiology of fever
   - ☐ Chest x-ray normal
   - ☐ No labs done OR lab results pending
   - ☐ No x-rays done OR x-ray results pending
   - ☐ None of the above

3. Based on the physical exam and work-up done for suspected abscess indicate which two of the following are present. ***Select all that apply***

   - ☐ Localized tenderness or rebound tenderness
   - ☐ Temperature greater than 100.4 F (38.0 C)
   - ☐ White blood cell (WBC) count greater than normal
   - ☐ Erythrocyte sedimentation rate (ESR) greater than normal
   - ☐ No labs done
   - ☐ None of the above

4. Which of the following best describe the reason a follow up CT scan is being requested for a known abscess, PID, or tubo-ovarian abscess? ***Select one***

   - ☐ Symptoms or findings unimproved after drainage AND IV antibiotics for at least two (2) days
   - ☐ Symptoms or findings unimproved after IV antibiotics for at least a week
   - ☐ New or significant worsening of pain or mass - Full clinical review MAY BE required. Attach clinical documentation including imaging results, history, physical exam, and reason for CT scan.
   - ☐ New or worsening temperature sustained over 100.4 F (38.0 C)
   - ☐ WBC increasing and above normal
   - ☐ None of the above

5. For suspected or known PID or tubo-ovarian abscess, indicate which one of the following is documented in the physical exam. ***Select one***

- ☐ Uterine pain
- ☐ Cervical motion tenderness
- ☐ Adnexal tenderness
- ☐ Pelvic examination not done or refused
- ☐ None of the above

6. Which of the following is documented as part of the work-up for PID or tubo-ovarian abscess? ***Select one***

- ☐ White blood cell (WBC) or C-reactive protein (CRP) above normal
- ☐ Temperature above 100.4 F (38.0 C)
- ☐ Erythrocyte sedimentation rate (ESR) greater than normal
- ☐ Purulent discharge
- ☐ Gonorrhea and/or Chlamydia testing positive
- ☐ Greater than 5 WBCs in vaginal fluid
- ☐ No labs done
- ☐ None of the above

7. Has an ectopic pregnancy been excluded by a negative human chorionic gonadotropin (HCG) test? ***Select one***

- ☐ Yes
- ☐ No
- ☐ Unknown or results pending

8. What are the results of the ultrasound (US) done as part of the work-up? ***Select one***

- ☐ US diagnosed PID or tubo-ovarian abscess
- ☐ US was done but was not diagnostic for PID or tubo-ovarian abscess
- ☐ US results are pending
- ☐ US has not been done
- ☐ None of the above

END SECTION G – CT Abdomen and Pelvis for Abscess, Infection, or Fever