Midwest Thermography
Trusted Partners in Thermal Imaging

Medical Thermal Imaging Consent

Patient's Name:_____ Age:_____ Date:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____ Cell Phone:_____

E-Mail:_____ Referred By: _____

☐ Check here to have your report and history forms sent to your doctor at Integrative Medical Specialists.

Please Send a Copy to (Please include City and State):

1)_____

2)_____

Instructions: Please read the following carefully. If you are in agreement with this consent form, sign and date it at the bottom. Please feel free to ask questions if there is anything that you do not understand on this form.

Thermography is a procedure utilizing digital infrared imaging cameras to visualize and obtain an image of the infrared heat coming off the surface of the skin. The thermographic procedure is performed in order to analyze temperature patterns on the body that may or may not indicate the presence of a disease process. Consequently, a normal thermogram does not rule out the presence of significant pathology.

Thermography is used along with X-ray, CT, MRI, mammography, ultrasounds and other imaging procedures and is not a stand-alone examination tool. Like other imaging tests it is an adjunctive tool, which while reliable should be utilized by the patient's treating physician along with other tests and analyses to arrive at a provisional or more complete diagnosis. No surgical procedure should be based on thermal imaging alone. Additional examination procedures, which depend on the nature of the condition and/or body region, are needed to achieve a final diagnosis. Thermography must not be confused with EBT or CT full body scanning. EBT and CT body scanning are structural imaging technologies, which look for the physical existence of tumors and other body structure changes while thermography does not. This office provides only the thermographic component of a complete evaluation.

I understand that I will be disrobed (from the waist up for breast exams, and buttocks exposed for lower body exams) during part of the examination for both imaging and to allow for the surface temperature of my body to acclimate with the room. I have also been informed in advance that a female technician will be in the room to operate the thermal imaging camera. My body will be imaged with a digital infrared camera. I understand that this procedure does not use radiation. It is not harmful to me. Its sole function is to produce an image of the heat coming off my body. I also understand that a brief physical examination of any suspect areas found on the thermographic images may be performed in order to fully characterize the findings.

The information provided will be made available to your doctor upon request for further work-up should an abnormality be detected. I have been informed about pre-examination preparation to insure the most accurate thermographic examination possible, and have complied with this protocol.

Having understood the above, and having received satisfactory answers to any and all questions that I may have had concerning the purpose and outcome, risk factors and benefits of a thermographic examination, as well as the utilization of the procedure, I hereby consent to both initial and subsequent thermographic examinations. I also understand that thermography is not a substitute for mammography, ultrasounds, CT, MRI or any other form of imaging.

Patient's (Guardian's) Name:_____ Date: _____
(Please Print)

Patient's (Guardian's) Signature: _____ Date: _____

25055 W. Valley Parkway • Suite 204 • Olathe, KS 66061 • Phone (913) 953-8633 • Fax (913) 825-6115 • www.mwthermography.com

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Thermal Imaging Instructions

Name _____ DOB_____

Body Temperature _____ Room Temperature _____ Technician _____

Welcome to Midwest Thermography. Before you arrive for your thermographic examination, certain protocols must be followed in order to ensure that your images reflect accurate information. Please check each box confirming the following instructions have been followed.

Please bring a list medications you are currently taking as well as any prior examination reports that describe breast findings you are concerned about.

- No recent sunburn or skin burn of any kind. Any laser treatments to the areas being imaged must be done 5 days prior to the exam.
- Allow 4-6 weeks after biopsy before imaging and allow 3 months post radiation.
- No Vitamin C IV drips, sauna or hot tub 24 hours prior to the thermal imaging.
- No use of deodorants, lotions, oils, creams (including hormone creams), powders, perfume, body sprays or makeup on the areas being imaged.
- No shaving of the areas to be imaged for at least 6 hours prior to the exam.
- No treatment (chiropractic, acupuncture, massage, TENS, physical therapy, electrical muscle stimulation, ultrasound, hot or cold pack use) or any physical stimulation of the areas to be imaged for 24 hours prior to the exam.
- No exercise 4 hours prior to the exam.
- No smoking for 2 hours prior to the exam.
- No bathing or showering for 1 hours prior to the exam.
- If you are nursing, avoid nursing 1 hour prior to the exam.
- For menstruating women, imaging must be done at least 3 days before or 3 days after menstruation.
- For head and neck imaging, do not floss, brush your teeth, chew gum or drink hot liquids 1 hours prior to the exam.

Please note:

During the examination you will be disrobed (from the waist up for breast exams, and buttocks exposed for lower body exams.) Shoes and socks will also be removed for every scan. If you are very cold sensitive bring or wear warm coverings for the areas not being imaged. The imaging room temperature is around 68 degrees F (21 degrees C.) You will acclimate in the room for 15 minutes prior to the test. A female technician is provided for all our female patients.

By signing below, I certify that I have adhered to all of the above instructions, and I understand that if I have not, it can render inaccurate test results with no fault to the technician or Midwest Thermography.

Signature:_____ Date:_____

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Please print out your completed form & bring it with you to your appointment

Imaging Center _____

Initial Breast Health History

Name: _____ Age: _____ Date: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

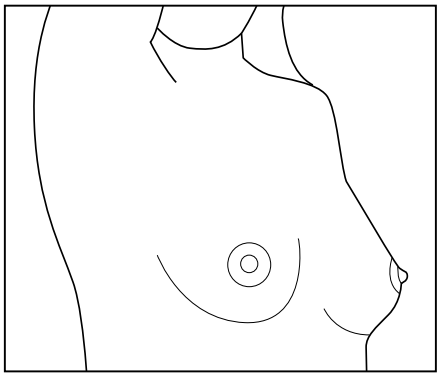
Daytime Phone #: _____ Date of Birth: _____ Sex: ☐ F ☐ M

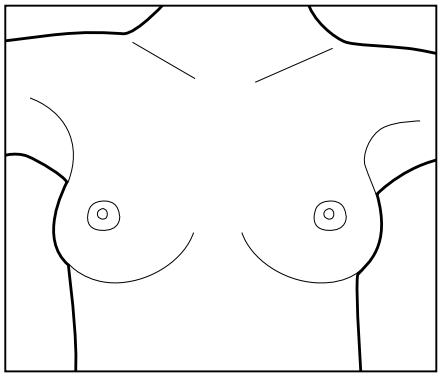
Describe any current breast concerns such as lumps, pain, or abnormal examination findings:

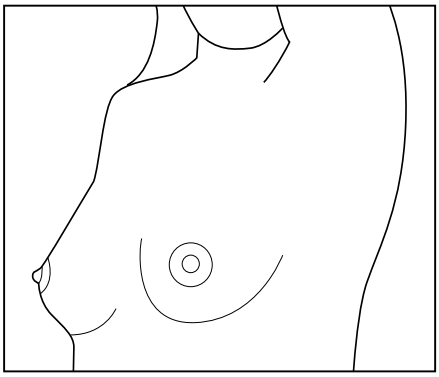
_____

_____

MARK THE AREA OF ANY NEW CONCERN ON THE DIAGRAM:







_____ _____ _____

_____ _____ _____

_____ _____ _____

Last Physical Breast Examination: Date _____

Results: ☐ Normal ☐ Other _____

_____

Mammogram: Date _____

Results: ☐ Normal ☐ Other _____

_____

Other Breast Tests (Ultrasound, MRI or Biopsy etc.) List test, date and results _____

_____

_____

COMPLETE ALL THAT APPLY:

☐ Diagnosed with breast cancer: Date of diagnosis _____,

Location of cancer and type, if known _____

_____

☐ Lumpectomy ☐ Mastectomy ☐ Reconstruction: Date and details of procedure:

_____

_____

☐ Radiation treatment: Date last performed: _____

☐ Chemotherapy: Since: _____

☐ Other treatment _____

☐ Fibrocystic breasts ☐ Y ☐ N, Cystic breasts ☐ Y ☐ N Other breast conditions

_____

☐ Breast surgery other than for cancer (benign lumpectomy, implants, reductions, etc.).

Date and procedure: _____

☐ Past injury to the breasts: Provide date, description and location _____

_____

☐ Birth control pills use: Duration: _____ Currently taking: ☐ Y ☐ N

☐ Prescription hormone replacement use including bioidentical:

Duration: _____ Currently taking: ☐ Y ☐ N

List types: _____

_____

☐ Non-prescription hormonal cream use and/or supplements to balance female hormones or thyroid.

Currently taking: ☐ Y ☐ N

List types: _____

☐ Other medications: List types: _____

_____

☐ Breast feeding: Currently ☐ Y ☐ N, Number of children nursed for over 1 month: _____

☐ Pregnant: If not, current cycle day (# of days since 1st day of period) _____

☐ Menopause: Experiencing symptoms of menopause or perimenopause: ☐ Y ☐ N

Age of last menses, if it has stopped: _____

☐ Both (not one) ovaries removed: ☐ Y ☐ N, Age (or ages) of removal: _____

☐ Family history of breast cancer: List family member(s): _____

_____

Imaging Center _____

Doctor in charge of your breast health:

Name: _____

Address: _____

Zip: _____ Phone: _____

May we send your doctor the report? ☐ Y ☐ N

CONSENT FOR TESTING PROCEDURE

Thermal Imaging of the breasts (otherwise known as breast thermography) measures surface temperature and provides information which may be used to help determine current and/or future risk for breast disease. Thermography can not diagnose breast cancer or rule out its presence. Some cancers do not produce sufficient temperature changes at the surface of the breasts to be seen with thermography. It does not replace mammography or any other breast examination. Thermal Imaging has no known risks or side effects associated with its use. ***Initial*** _____

I authorize this clinic's personnel to perform this thermal imaging examination and to send the images to **Robert L. Kane, DC, DABCT** for interpretation. ***Initial*** _____

I have read and complied with the pre-examination instructions for proper thermal imaging. ***Initial*** _____

Print Name: _____ Signature: _____

Date: _____

PLEASE DO NOT WRITE IN THIS SECTION

Tech: _____ Patient Temp: _____ F Laboratory Temp: _____ C

OFFICE USE ONLY

Cranial History

Name:_____ Sex:____ Age:_____ Date:_____

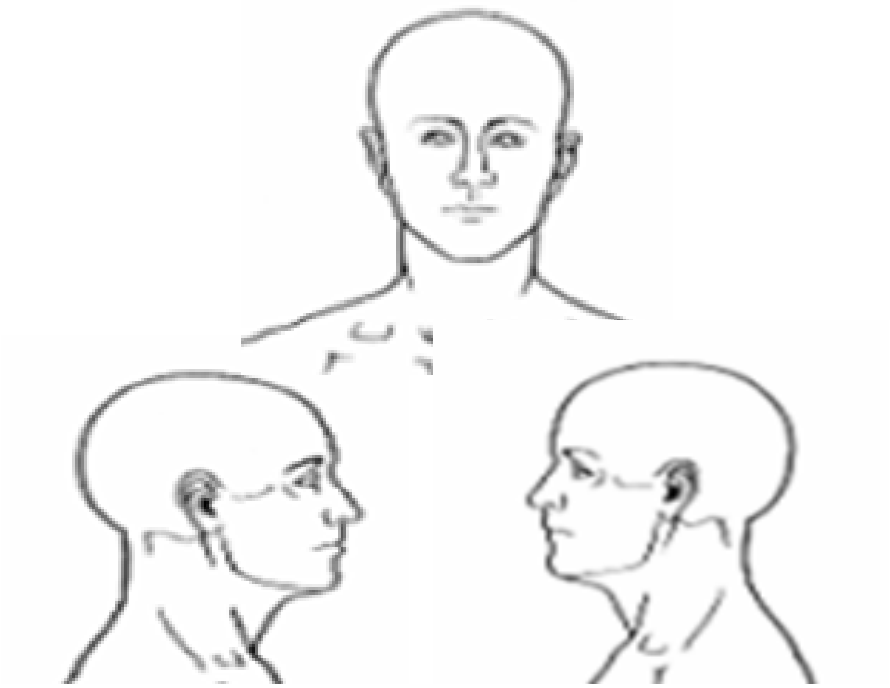
Address:_____

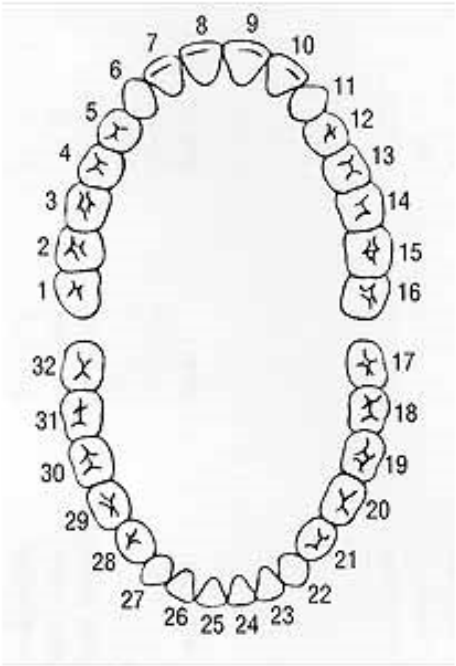
City:_____ State:_____ Zip:_____

Phone #:_____ Referred by:_____

How did you hear about us? ❒ Internet ❒ Person Other _____

Please mark the region of your concern on the diagrams below.





Please describe any specific concerns:

❒ Dental _____

❒ Sinuses _____

❒ Facial Pain or Numbing _____

❒ Thyroid Concerns_____

❒ Lumps in Neck_____

❒ Dizziness or Lightheadedness_____

❒ Other _____

Do you have any history of:

❒ Stroke ❒ Cardiovascular Disease ❒ Dizziness ❒ Fainting

Please Describe: _____

❒ Past Injuries to the face

Please Describe: _____

Do you have any diagnosed diseases?

Please Describe: _____

Do you have any past surgeries to the head, face or mouth?

Please Describe: _____

Full Body and Pain History

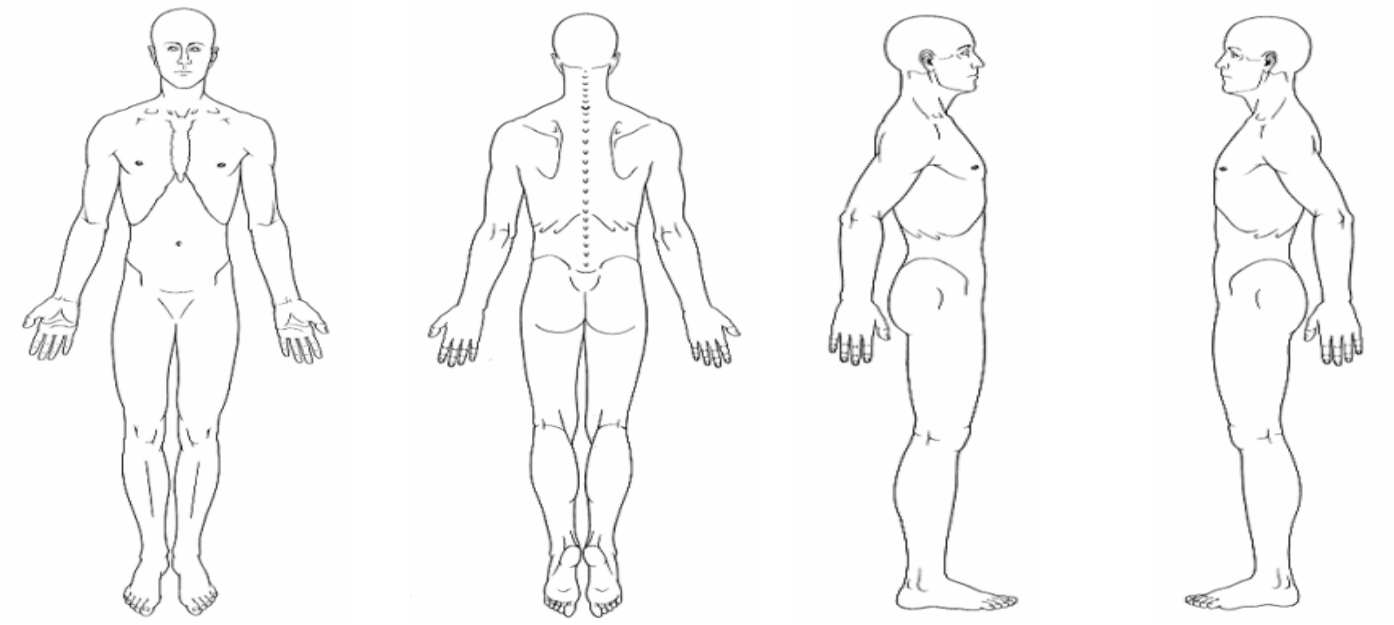
Name:_____ Email: _____Date: _____

Address:_____City:_____State:_____Zip:_____

Phone #:_____ Date of Birth: _____ Age:_____ Sex:_____

Referred by:_____

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Mild: Annoyance Moderate: Some Limitations Severe: Pain Killers Needed

Describe your symptoms: _____

How and when did this start? _____

Were you examined for this complaint? _____

Date and Results: _____

_____

What increases your symptoms? _____

What decreases your symptoms? _____

What medications are you taking? _____

_____

List any treatments you have had: _____

List any other medical conditions: _____

List any past surgeries: _____

List and describe the location of any rash or marking on your body: _____

_____

Practitioner in charge of your health: Name: _____

Address: _____

_____ Zip _____

Phone: _____

May we send him or her your report? ❒ Y ❒ N

Release for Testing Procedure

Thermal Imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging examinations.

I have complied with the pre-examination instructions for proper thermal imaging

Print Name _____ **Signature** _____ **Date** _____

Please do not write in this section

❒ Initial Exam ❒ Re-Exam Tech _____

Patient T = _____ F Laboratory Temperature _____ C

Additional info: _____

_____

_____

_____

_____

_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Midwest Thermography, (MWT) has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact MWT at 913-953-8633.

I also understand that I am entitled to receive updates upon request if MWT amends or changes its Notice of Privacy Practices in a material way.

I choose to designate the individuals listed below as my primary contacts. MWT personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Patient's Name _____ Patient's DOB _____

Contact Name _____ Contact Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

_____ _____

Signature (Patient, Parent, Authorized Signature) Date

FOR OFFICE USE ONLY

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____
Signature and Title

_____
Date

This section is to be completed by MWT if unable to obtain written acknowledgement from patient.