Spokane Thermal Imaging
Patient Preparation Checklist

It is crucial that you follow these restrictions to achieve accurate results from your thermal scan.

- No prolonged sun exposure (especially sunburn) to the body area being imaged for five days prior to your exam.
- Avoid a strenuous workout, exercise or weight training for 24 hours prior to your test
- No sexual activity for 24 hours prior.
- If you are nursing, please try to nurse as far from one hour prior to the exam as possible.
- Do not use a car seat heater while travelling to your thermal imaging appointment.
- No physical therapy, massage, EMS, TENS, ultrasound treatment, acupuncture, chiropractic, physical/sexual stimulation, hot or cold pack use for 24 hours before your exam.
- Do not use lotions, powder, deodorant, antiperspirant, perfume, scented products, make up, or anything topical on the body area to be imaged the day of your exam. Our clinic has a NO CHEMICALS/NO SCENTS policy.
- If any areas of the body (as included in the images) are to be shaved, this should be done the evening before the exam. Do NOT shave under your arms the day of your exam.
- Allow at least 4 hours after a hot shower, hydrotherapy, hot tub or sauna.
- Do not smoke or have any caffeine for 2 hours prior to your exam.
- If bathing, it must be no closer than 1 hour before your exam.
- If not contraindicated by your doctor, avoid the use of pain medications the day of your exam. You must consult with your doctor prior to any change of medication.
- If you have had any medical procedure within the past 12 weeks, please notify our office before coming in for your appointment.
- Let the technician know if you have had any recent skin lesions or blunt trauma to the area to be scanned.

Please note: For breast exams you will be asked to disrobe from the waist up.

Breast Health History

Name:_____ Age:_____ Date of Scan: _____

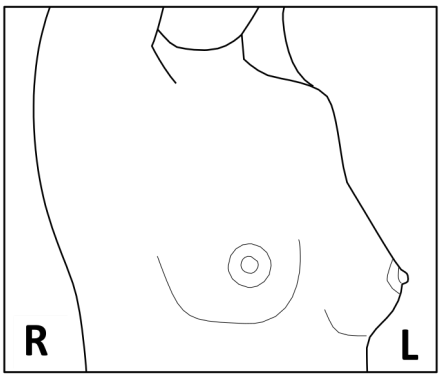
Date of Birth:_____ Sex: F ☐ M ☐ Initial Scan ☐ Follow-up Scan ☐

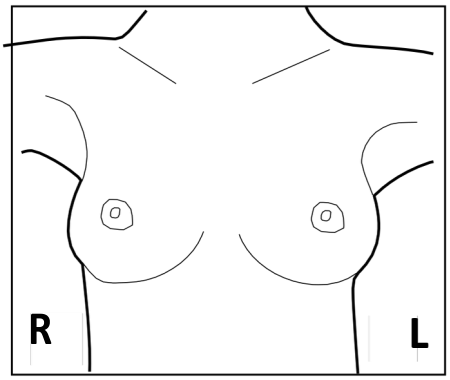
Describe any current breast concerns such as lumps, pain, skin changes, radiographic findings or other concerns:

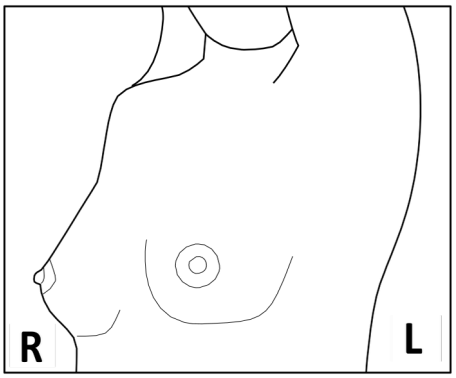
_____

_____

MARK THE AREA OF ANY CURRENT CONCERN ON THE DIAGRAM:







_____ _____ _____

_____ _____ _____

Last Physical Breast Examination by a Health Care Provider ☐ None

Date: _____ Results: ☐ Normal Other_____

Last Mammogram: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐ Normal Other_____

Last Breast Ultrasound:

☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐ Normal Other_____

Last Breast MRI: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐ Normal Other_____

Breast Biopsy: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐ Benign ☐ Pre-Cancer ☐ Cancer

Section 1: Breast Cancer ☐ None ☐ Left ☐ Right ☐ Both Date of Diagnosis:_____

Cancer Treatment:

☐ Lumpectomy: Date:_____ ☐ Mastectomy: Date: _____

☐ Reconstruction: Date: _____ ☐ Radiation treatment: Date of last treatment _____

Other treatment _____

Section 2: General

Benign Breast Surgery: ☐ None Lumpectomy: Date:_____ ☐ Right ☐ Left

Implants: Date:_____ Reduction: Date:_____

Fibrocystic breasts, Breast Cysts, or General Breast Lumpiness ☐Yes ☐ No

Other benign breast conditions: ☐ None ☐ Yes _____

Currently Breast feeding: ☐No

☐ Yes - Last Breast Nursed: ☐ Right ☐ Left Breast Most Favored: ☐ Right ☐ Left

Pregnant: ☐ Yes ☐ No - current cycle day (# of days since 1st day of period):_____

Menopause: ☐ No ☐ Yes - Age of last menses: _____

Currently experiencing symptoms of: ☐ Menopause ☐ Perimenopause ☐ Neither

Both ovaries removed: ☐ Yes - Check only if both have been removed ☐ No

Family history of breast cancer: ☐ Yes ☐ No

Past injury to the breasts: ☐None ☐ Right ☐ Left ☐ Both Date of Injury:_____

Section 3: Selected Hormones and Factors Effecting Them

Current Hormones: ☐ None

☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ Thyroid hormone

Current supplements to support the following: ☐ None

☐ Breast Health ☐ Hormonal Balance ☐ Inflammation ☐ Thyroid Function

Are you currently engaged in any lifestyle activities or diet designed to: ☐ None

☐ Promote breast health ☐ Reduce inflammation ☐ Promote hormonal balance

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PLEASE DO NOT WRITE IN THIS SECTION

Tech:_____ Patient Temp:_____F Laboratory Temp:_____C

INFORMED CONSENT FOR TESTING PROCEDURE

Thermal Breast Imaging (otherwise known as breast thermography) detects and visualizes the thermal emissions (temperature) occurring at the surface of the breasts. The purpose of the examination is to detect signs of inflammation or unusual blood vessel activity that could suggest risk for current and/or future risk for cancer. Initial ____

I understand that Thermal Breast Imaging is used only as an adjunct to primary screening examinations such as physical breast examination, mammography, breast ultrasound and breast MRI and does not replace any other breast examination or screening. I also understand that thermal imaging does not and cannot directly detect or be used to diagnose breast cancer. Nor can it rule out the presence of breast cancer since some cancers do not produce sufficient temperature changes at the surface of the breasts to be seen with thermography. Therefore, breast cancer may still be present despite thermal imaging revealing a low risk. For that reason, thermal imaging does not replace any other breast examination. All breast concerns including but not limited to skin changes, nipple discharge, lumps or other abnormalities, clinical findings and radiographic findings require evaluation by a medical doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing cancer to be detected. Initial _____

I confirm that I have followed the written pre-examination protocols for breast imaging provided to me before the examination. I understand that if I did not receive or follow these protocols, the accuracy of my examination may be compromised. Initial _____

By signing below, I hereby acknowledge that (1) I have read and understood each of the above paragraphs; (2) I have had an opportunity to ask any questions I may have had; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information with respect to thermal imaging to make an informed decision to undergo the procedure; (5) I understand no guarantee or warranty is being made that all risk for current and/or future cancer will be detected; and (6) I hereby authorize and consent to thermal imaging

_____	_____	_____
Print Name	Signature	Date

STATEMENT OF INDEPENDENT OPERATIONS:

I understand and agree that Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services (collectively referred to as "Kane Interpretive Services") is a California based company that contracts with the provider of your imaging services solely for the purpose of interpreting and reporting thermal imaging scans. Your provider is not an employee, officer, director, partner, representative or agent of Kane Interpretive Services. Nor is Kane Interpretive Services an employee, officer, director, partner, representative or agent of your provider. Kane Interpretive Services is a wholly separate business entity from your provider and does not oversee or supervise your provider's thermography operations. Kane Interpretive Services is not involved in the design, manufacture, marketing, sale, rental, distribution, installation, inspection, repair or modification of any machinery or products used by your provider. Rather, Kane Interpretive Services is an independent contractor hired by your provider solely to interpret thermal imaging data and to report the results. Kane Thermal Interpretive Services does not control, nor have the right to control, your provider's business, including its equipment, operations, advertising and/or representations. Kane Interpretive Services makes no promises, warranties or representations, express or implied, as to your provider's services. In addition, Kane Interpretive Services owes no duty of care to me in connection with provider's services, including no duty to screen provider, no duty to protect or warn me of any actions or inactions of provider and no duty to investigate, communicate or mitigate any risks, known or unknown, relating to provider's services. I assume all duty of reasonable care to select, screen and monitor provider's services for my own safety and protection.

By signing this Statement of Independent Operations, I understand and agree with the foregoing and further agree that Dr. Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services is only responsible to me for the content of the thermal imaging report and its accompanying reporting guide.

_____	_____	_____
Print Name	Signature	Date

Additional Technician Notes:

SPOKANE THERMAL IMAGING PATIENT INFORMATION AND IMAGING CONSENT

Name_____

Date of exam_____ Cell phone_____

Address_____

City_____ State____ Zip code_____

Spokane Thermal Imaging, LLC
1801 W Broadway
Spokane, WA 99201

Informed Consent for Digital Thermographic Imaging

I_____ give Spokane Thermal Imaging permission to electronically transfer my medical images via email, to Beyond Pink and to the Beyond Pink follow up provider that I have chosen. I have read and understand the HIPPA consent form for Beyond Pink and Spokane Thermal Imaging. I have been provided a HIPPA form from Beyond Pink and understand that I can request one from Spokane Thermal Imaging at the time of my appointment.

HIPPA Privacy and Release of Information Authorization

I, _____, hereby authorize Spokane Thermal Imaging LLC to use and disclose protected health information (e.g. information related to my thermal imaging exam, images and thermal imaging reports which identifies my name and date of birth) to the follow up physician and/or to Beyond Pink Spokane (if I am a Beyond Pink grant recipient) for the purpose of follow up care.

I understand that any personal health information released to the person, physician or organization identified above may be subject to re-disclosure by such person/physician/organization and may no longer protected by applicable federal and state privacy laws.

I understand I have the right to revoke this authorization by providing written notice to Spokane Thermal Imaging. This authorization may not be revoked if Spokane Thermal Imaging has acted on this authorization prior to receiving my written notice. I understand I have a right to a copy of this authorization.

I also understand that this is a voluntary authorization, and I can refuse to sign this authorization. I agree to bring any concerns or complaints regarding privacy to the attention of Spokane Thermal Imaging, LLC.

I further understand that I have access to my records in accordance to state and federal laws.

By signing this form, I acknowledge my agreement to the terms set forth in this HIPPA privacy and release of Information form. I also understand that this consent shall remain in force from this day forward.

_____ _____

PRINTED PATIENT NAME DATE

_____

SIGNATURE OF PATIENT