Midwest Thermography
Trusted Partners in Thermal Imaging

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 to ensure that your images reflect accurate information. Please initial each line confirming the following instructions have been followed:

Initials

_____ Avoid sunbathing, artificial tanning, waxing and laser treatments to the areas being imaged. These must be done 5 days prior to the exam. If there are any burns or wounds on the areas being imaged, imaging may need to be postponed.

_____ Allow a minimum of 4-6 weeks after biopsy and 3 months after radiation before imaging. Elevated temperatures can still be detected from tissue healing up to a year after a lumpectomy or masectomy.

_____ No IV, ozone, or injectable therapies or treatments 36 hours prior to imaging.

_____ Do not use deodorants (including natural deodorants), antiperspirants, lotions, oils, creams (including hormone creams), powders, perfume, body sprays, makeup or anything topical on the areas being imaged.

_____ Avoid shaving the areas to be imaged for at least 24 hours prior to the exam. This includes underarms for breast thermograms, underarms and face for upper body thermograms, and legs for lower body thermograms.

_____ Avoid physical stimulation of the body such as chiropractic, sexual activity, massage, TENS, physical therapy, electrical muscle stimulation (EMS), sauna, hot tub, steam room, ultrasound, mammography, hot or cold pack use for 24 hours prior to the exam.

_____ Avoid mammography, CT scans, MRI, and X-Ray 3 days prior to testing.

_____ No exercise the day of the exam.

_____ No smoking for 2 hours prior to the exam.

_____ No showering for 1 hour prior to the exam. No baths 24 hours prior to the exam.

_____ If you are nursing, avoid nursing at least 1 hour prior to the exam. Please note the last time nursed and check which breast and/or both, if applicable. Time: _____ Left Breast_____ Right Breast_____

_____ For head and neck imaging, do not floss, brush your teeth, chew gum or drink hot liquids 1 hour prior to the exam. Refrain from dentistry and dental cleanings at least 3 days prior to the test.

_____ If not contraindicated by your doctor, avoid taking pain medications or vasoactive drugs the day of the exam.

_____ If you have a fever, severe congestion or cough, please reschedule

During the examination you will be disrobed (from the waist up for breast exams, underwear may be worn for women and shorts for men for lower body exams.) Shoes and socks must also be removed. If you are 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.

Please bring a list of medications you are currently taking, as well as any prior imaging reports that describe a finding you are concerned about.

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.

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

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

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

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Medical Thermal Imaging Consent

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

Address:_____ City:_____

State:_____ Zip:_____ Primary Phone:_____ Secondary Phone:_____

E-Mail:_____ Referred By: _____

☐ I am a patient of Dr. Diane Diehn or Dr. Emily Guse and would like them to receive a copy of my report.

Please Mail a Copy to my Doctor or Healthcare Practitioner Listed Below:
(Please include Street Address, Suite Number, City and State):

1)_____

2)_____

I understand that I will be disrobed (from the waist up for breast exams, and underwear or shorts only 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. Initial _____

Thermal imaging is a technology which measures the surface temperature of the body using infrared cameras and is analyzed to provide physiological information as an adjunct to standard screening and diagnostic testing. Initial _____

I understand that thermal imaging does not and cannot directly detect or be used to diagnose injury or disease of any kind and that the information is designed to be used with other examinations as an aid to the diagnostic process. Nor can it rule out the presence of injury or disease since some conditions do not produce sufficient temperature changes at the surface of the body to be seen with thermography. Therefore, injury or disease may still be present despite a lack of thermal findings present on examination. All concerns require evaluation by a 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 condition to be detected. Initial _____

I further understand that not all organ systems, dental conditions, and medical conditions will produce thermal findings that will enable detection. Therefore, I understand that this test cannot determine if an organ or the body is diseased or healthy and it cannot diagnose disease. It is a functional test which may provide general regions to evaluate more thoroughly by a health care provider. It cannot replace or rule out the need for examination or additional testing.
Initial _____

I confirm that I have followed the written pre-examination protocols for thermal imaging provided to me before the examination. I understand that if I did not receive and 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 injury or disease will be detected; and (6) I hereby authorize and consent to thermal imaging.

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

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

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Breast Health History

Imaging Center_____

Name:_____ Age:_____ Date of Scan: _____

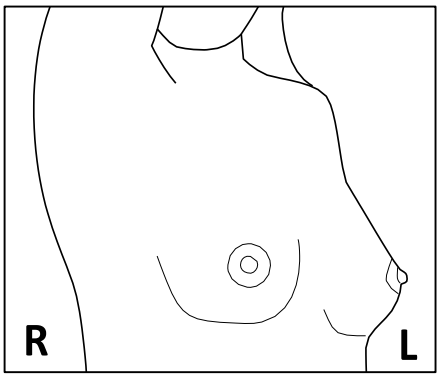
Date of Birth:_____ Sex: F ☐ M ☐ Initial Scan ☐ Follow-up Scan ☐

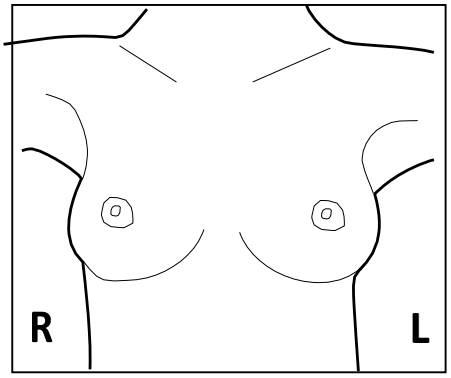
Describe any current breast concerns such as lumps, pain, skin changes, radiographic findings or other concerns:

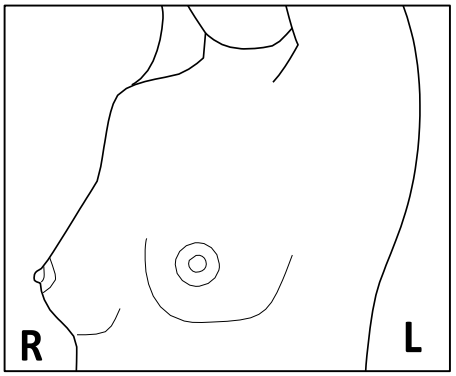
_____

_____

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

Imaging Center_____

Cranial Health History

Name:_____ Age:_____ Date of Scan:_____

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

Please describe any current concerns with:

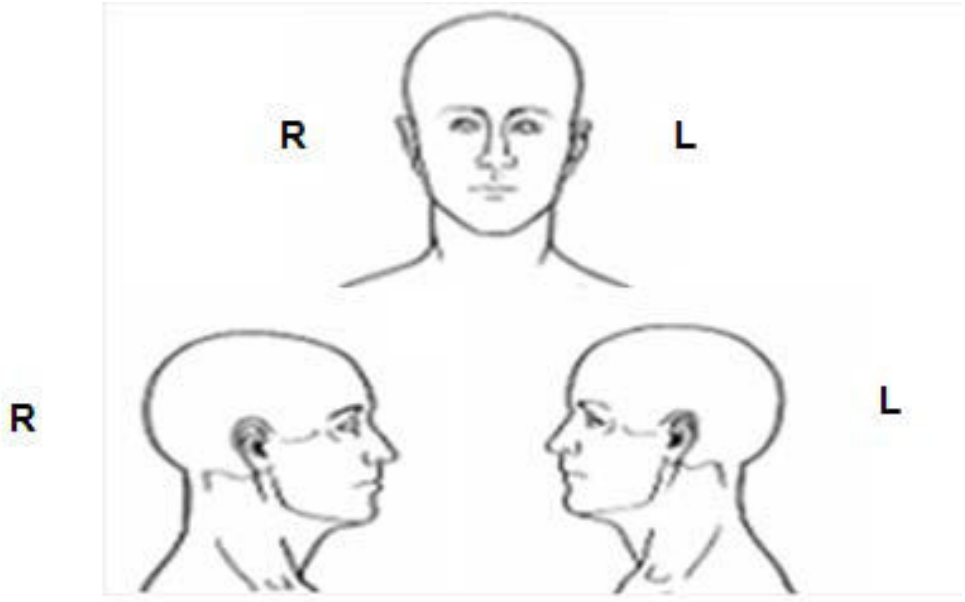
Face and Anterior neck:

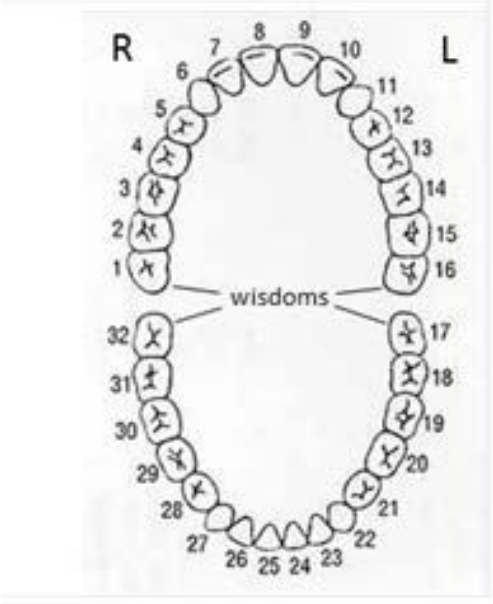
☐ Facial Pain ☐ Facial Numbing ☐Tooth/Tooth Socket Pain ☐TMJ Pain or Clicking
☐ Sinus Concerns ☐ Allergies ☐ Thyroid ☐ Lymph Node
☐ Headaches

☐ Please Describe_____

_____
_____
_____
_____
_____

Place an “x” on the diagram in the area of concern.





History of: ☐ None

☐ Stroke ☐ Cardiovascular Disease ☐ Dizziness ☐ Fainting

Please Describe: _____

History of: Root Canal ☐ Yes ☐ No Wisdom Tooth Extraction ☐ Yes ☐ No

Please Describe: _____

Please do not write in this section

Tech _____ Patient T = _____ F Laboratory Temperature _____ C

Additional Technician Notes

INFORMED CONSENT FOR TESTING PROCEDURE

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I further understand that not all dental, thyroid, and other conditions of the head and neck will produce thermal findings that will enable detection. Therefore I understand that this test cannot determine if these structures are diseased or healthy and it cannot diagnose disease. It is a functional test which may provide general regions to evaluate more thoroughly by a health care provider. It cannot replace or rule out the need for examination or additional testing.
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Print Name	Signature	Date

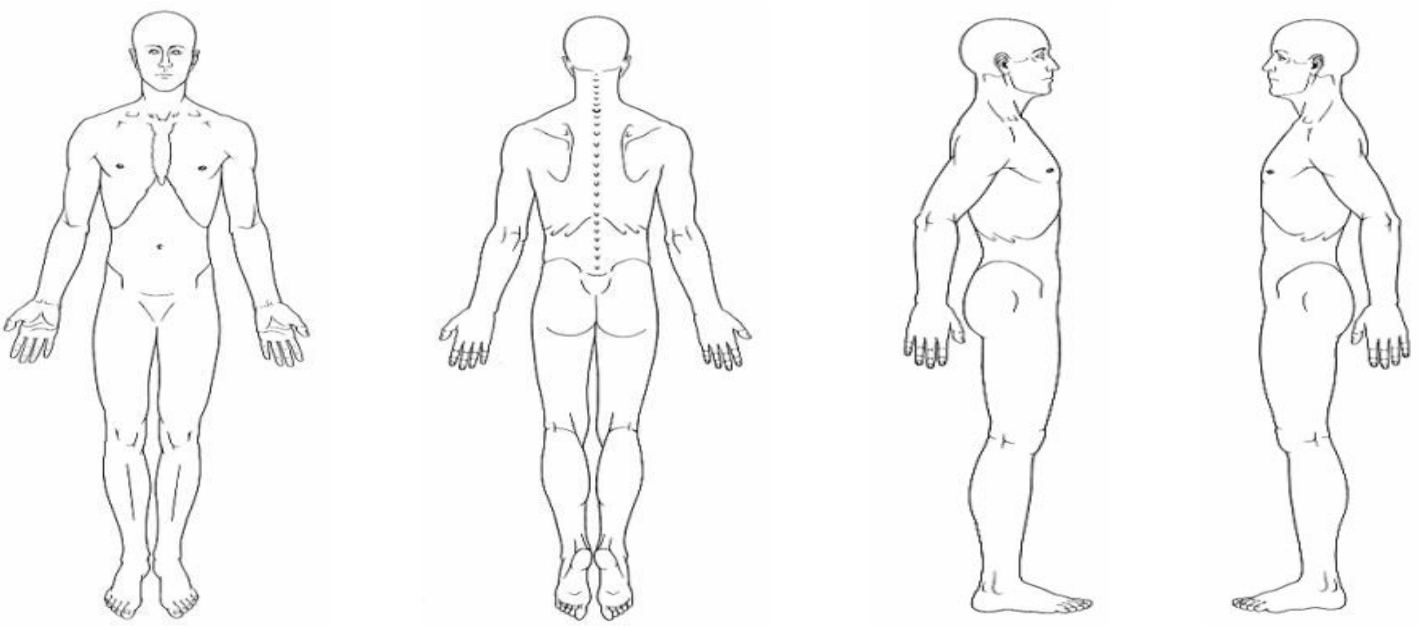
Imaging Center_____

Full Body and Pain History

Name:_____ Age:_____ Date of Scan:_____

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

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: _____

Please do not write in this section

Tech: _____ Patient T: _____ F Laboratory Temperature: _____ C

Additional Technician Notes

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