De Novo Scan
Clinical Thermography

Patient Pre-Screen Information

Screening with Digital Infrared Thermal Imaging

Purpose of test:

Early detection of abnormal changes in the breasts, lymphatic system and other areas of the body that may require or may not require further diagnostic testing (depending upon the findings via medical interpretation).

Patient preparation:

- You must wait at least three months after major breast surgery, completion of chemotherapy, or radiation before a thermal exam.
- You must wait at least one month after a biopsy or minor surgery
- Avoid tanning or sunburn for at least one week before the exam
- Do not eat one hour prior to your exam
- Do not eat or drink caffeinated products two hours prior to your exam
- Do not smoke or use any products containing nicotine two hours prior to your exam
- Do not exercise at least 12 hours prior to your exam
- Do not use lotions, powders, or deodorants the day of your exam
- Avoid taking any medications or supplements on the day of your exam if possible
- No alcohol for at least two days prior to your scan. Too much alcohol will affect hormone levels which will show up in your scan.
- Please wear loose fitted clothing
- For Half Body or Full Body Scans, hair will need to be pulled up off the neck, face/forehead (we have disposable hair supplies for your convenience)
- Please inform your Thermography Technician about any recent skin lesions or bruising, rosacea or any other skin disorders as it may cause false positives on reports.
- Please note that the camera will not be able to see through thick hair such as thick chest hair, thick body hair, thick shoulder/back hair. Please shave closely at least 3 days prior to your scan. (This seems apply more for men than women).

Procedure:

- To receive accurate results, the equilibrating time is 15 minutes and temperature is between 68-72 degrees.
- You will be asked to disrobe according to the type of scan chosen; the images, again depending on the type of study being done, will take approximately 20 – 45 minutes.

Patient Forms:

- To ensure the appropriate allotted time is allowed for your appointment, please print and complete the following patient forms and bring with you to your appointment.

De Novo Scan
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SCOTTSDALE
8075 E. Morgan Tr., Suite 2 | Scottsdale, AZ 85258
Ph: 480.284.2222

PATIENT CONSENT FORM

NAME:		**DOB:**	
ADDRESS:		**CITY/ST/ZIP:**	
CELL PHONE:		**HOME PHONE:**	
EMAIL:		**HOW DID YOU FIND US?:**	
PHYSICIAN'S INFO:			

SELECT SCAN: ____ **Breast Scan** ____ **Half Body Scan** ____ **Full Body Scan** ____ **Spot View(s)**

According to a study in the American Journal of Radiology Jan. '03, Thermography is 97% sensitive in detecting breast cancer. In comparison, mammography can only detect 35% of breast cancers (New England Journal of Medicine July '04, Lancet May '05, Journal of the American Medical Association September '04).

_____I understand that the report generated from my images is intended for use by a trained healthcare provider to assist in evaluation, diagnosis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis or treatment.

_____It is further understood that my thermal images are a unique personal fingerprint and that abnormal patterns can only be determined to be abnormal both by use of comparison of left and right sides of my body and also by examining changes over time. To establish a baseline, it is recommended that a repeat exam is done within three to six months to make an interval comparison. New examinations at one year intervals will be the norm and will reveal any interval abnormalities. The initial exams will be kept on file for immediate comparison.

_____I understand the report will not tell me whether I have an illness, disease, cancer or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. No diagnosis of malignant disease can be made without a biopsy of the mass or lump regardless of the type of scan.

_____I hereby authorize De Novo Scan and any of its employees to disclose my patient health information to Physician's Insight, the group of physicians interpreting my thermal images. I agree that if the initial exams are highly suspicious for a potential serious problem to accept advice for a referral to traditional imaging methods such as ultrasound (also non-invasive with zero radiation), mammography, breast MRIs or PET scans. A structural evaluation by one of these modalities is needed.

_____I understand that my report will be sent to me via electronic mail (email). If by chance an email address is not available, my report will then be sent to me via US postal service. I also acknowledge that there is a fee of $10.00 should I need an additional printed copy of my report.

_____I understand that a Superbill will be provided to me upon request and that my insurance may not cover my procedure.

By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information to the reading doctor and the receipt of information from the reading doctor in the pursuit of comprehensive evaluation and treatment relating to the services provided by De Novo Scan and Physicians Insight.

Signature: _____**Date:**_____

Print Name: _____

Confidential Questionnaire

Breast Scan

Name_____Birth Date_____Today's Date_____

Address_____City_____State_____Zip_____

Cell Phone_____Home Phone_____

E-Mail Address_____

Referring Physician or Physician Name/Info_____

Is there a specific reason or concern for this exam?

			Yes	No
1.	**Have you recently had any of these breast symptoms?** (**mark only if "yes"**)		___	___
		Left / **Right**		
	Pain/Tenderness	___ / ___		
	Lumps	___ / ___		
	Change in breast size	___ / ___		
	Areas of skin changes thickening or dimpling	___ / ___		
	Excretions or changes of the nipple	___ / ___		
2.	**Are any of the above symptoms cycle related?**		___	___
3.	**Are you still having your periods? Date of last period** _____/_____/_____		___	___
4.	**Have you had a surgical hysterectomy?**		___	___
	If yes, date of surgery: _____/_____/_____ Complete ___ Partial ___			
	Reason for hysterectomy?: ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts			
	○ Cancer ○ Other_____			
5.	**Has anyone in your <u>immediate</u> family ever been treated for breast cancer?**		___	___
	If yes, note age ○ Mother ____ ○ Grandmother ____ ○ Sister____ ○ Daughter ____			
6.	**Have you ever been diagnosed with breast cancer?**		___	___
	If yes, date: Month _____ Year _____			
	Cancer type	○ Local ○ Metastatic ○ Lymph node involvement		
	Left breast	○ Inner ○ Outer ○ Nipple		
	Right breast	○ Inner ○ Outer ○ Nipple		
	Treatment	○ Surgery ○ Chemo ○ Radiation ○ None		
7.	**Have you ever been diagnosed with any other breast disease?**		___	___
	If yes, ○ Cysts/fibrocystic ○ Fibro Adenoma ○ Mastitis/inflammatory breast disease			

8. Have you had any cosmetic breast surgery or implants? ___ ___

If yes, date: Month_____ Year _____ ○ Silicone or ○ Saline

Experience: ○ Problems ○ No problems

9. Have you ever had any biopsies or any other surgeries to your breasts

	Yes	No

If yes, date: Month_____ Year_____

Left breast	○ Inner	○ Outer	○ Nipple
Right breast	○ Inner	○ Outer	○ Nipple
Results	○ Negative	○ Positive	○ Calcifications

10. Have you ever taken contraceptive pills for more than one year? ___ ___

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

11. Have you had <u>ESTROGEN</u> hormone replacement therapy (HRT)? ___ ___

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

12. Do you have an annual physical examination by a doctor? ___ ___

13. Do you perform a monthly self breast exam? ___ ___

14. Have you ever smoked? ___ ___

15. Have you ever been diagnosed with diabetes? ___ ___

16. Total mammograms? _____(if unsure, give best guess)

17. Date of last mammogram ____ / _____ / _____ Were you re-called? Y____ or N____ ___ ___

18. Your age at your first mammogram?_____

19. Number of full-term pregnancies? _____

20. Have you had breast ultrasound? ___ ___

If yes, date: ____/_____ Left ___ Right___ Results: Negative___ Positive ___

21. Have you had breast MRI? ___ ___

If yes, date: ____/_____ Left ___ Right___ Results: Negative___ Positive ___

Do you have any special concerns or are there any details related to the information above?

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.*

By signing below, I certify that I have read and understand the statement above and consent to the examination.

Print Name_____

Signature_____**Today's Date**_____