Pre-Thermographic Imaging Instructions

Welcome to Finlandia Health Technologies. Before you arrive for your breast thermogram, certain protocols must be followed in order to ensure that your images reflect accurate information. Please read the following instructions and strictly adhere to them.

- Avoid physical stimulation of the breasts (such as breast massage) for 24 hours before the exam.
- No prolonged sun exposure (especially sunburn) to the chest and breast areas 5 days prior to the exam.
- No warm or cold beverages 2 hours prior to imaging.
- On the day of the exam, please do not use any lotions, creams, powers, or makeup on the breasts, and no use of deodorants or antiperspirants.
- No shaving (or other types of hair removal) of the chest, breasts, or underarms for 24 hours prior to the exam.
- No treatment (chiropractic, acupuncture, TENS, physical therapy, electrical muscle stimulation, ultrasound, hot or cold pack use) of the neck, back, chest or breasts for 24 hours before the exam.
- No exercise 4 hours prior to the exam.
- If bathing, it must be no closer than 1 hour before the exam.
- Do not drink alcohol 12 hours prior to the test.
- If you are using pain medications, please avoid taking them for 4 hours prior to the examination. **You must consult with the prescribing physician for his or her consent prior to any change in medication use such as this.**

PLEASE NOTE: Please note that women who are nursing need to allow 12 weeks after completion of breast feeding before coming in for imaging.

During the examination you will be disrobed from the waist up for both imaging and to allow for the surface temperature of the body to equilibrate with the room. A female technician will be performing all your imaging.

If you have copies of any other test results (e.g. mammograms, ultrasounds, biopsies) please bring them with you. If you have any further questions, please contact us.

The total time necessary to complete the procedure is approximately 45 minutes.

I have read and understood and will comply with the instructions state above.

Client Name (Print):_____

Client Signature: _____

Date: _____

Retail Store & Pharmacy: 1111 West Broadway
Vancouver BC V6H 1G1
Phone: 604.733.5323
Fax: 604.484.0002

Health Centre: G104 – 2480 Spruce
Vancouver BC V6H 2P6
Phone: 604.734.7760
www.finlandiapharmacy.com

Finlandia
PHARMACY & NATURAL HEALTH CENTRE

Infrared Breast Imaging

Patient's Name:_____ **Date:**_____

Address:_____ **City:**_____ **Province:**_____

Postal Code:_____ **E-mail:**_____

Date of Birth: _____ **Phone #:**_____ **Age:**_____ **Gender:**_____

Have you ever been diagnosed with breast cancer? ❒ Y ❒ N Date: _____ ❒ R ❒ L Breast

Do you have a family history of breast cancer? If yes, who? _____

Date of your last mammogram: _____
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Date of your last breast ultrasound: _____ Were both breasts imaged? ❒ Y ❒ N
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Was a follow up biopsy recommended after your <u>last</u> mammogram, ultrasound, or MRI? ❒ Y ❒ N

Date of last physical breast exam by a doctor: _____ ❒ NML ❒ Lump ❒ Thickening – ❒ R ❒ L

What follow up tests did your doctor recommend after this last exam? _____

Date of any breast biopsies: _____ ❒ R ❒ L Breast

What was found on the biopsy? ❒ Cancer ❒ Other _____ ❒ R ❒ L Breast

Any breast surgeries? Date and what was done? _____ ❒ R ❒ L Breast

Have you had a mastectomy? ❒ Complete ❒ Partial Date: _____ ❒ R ❒ L Breast

Was the nipple removed? ❒ Y ❒ N Was the surface skin of the original breast entirely removed? ❒ Y ❒ N

Any breast reconstruction? What was done? (ex. trans flap, implant) _____ ❒ R ❒ L Breast

Any breast radiation treatment? Date of last treatment _____ ❒ R ❒ L Breast

Are you currently pregnant? ❒ Y ❒ N Are you currently nursing? ❒ Y ❒ N

Are you experiencing any of the following with your breasts: ❒ None

❒ Lump ❒ Thickening (date found _____; found by ❒ Self breast exam ❒ Doctor exam)

Pain: ❒ Dull ❒ Sharp ❒ Burning ❒ Stinging ❒ Tenderness ❒ The pain changes with my cycle

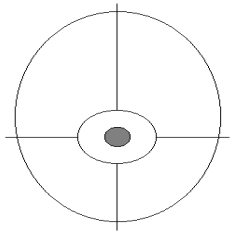
❒ Thickening ❒ Skin changes (❒ Color ❒ Texture ❒ Over the lump)

❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear ❒ Through 1 duct ❒ Through multiple ducts)

❒ R ❒ L Nipple retraction (❒ For many years ❒ Recently) ❒ R ❒ L Nipple changes (❒ Color ❒ Texture)

❒ Other _____

Place an [O] on the diagram in the exact area of the <u>lump</u>. [M] for a <u>finding on your mammogram / ultrasound / MRI</u>. [W] for an <u>area being watched</u>. [X] in the area of <u>pain</u>, <u>tenderness</u>, or <u>skin changes</u>. [#] in the area of <u>thickening</u>



RIGHT **LEFT**

High T:_____ Low T:____ **❒ Initial Exam** **❒ Re-Exam** Tech: _____

Pt T = _____ F Rm T = _____ C

❒ R ❒ L Nipple retraction ❒ R ❒ L Areola traction SLQ SMQ ILQ IMQ

❒ R ❒ L Skin surface bulge or dimple SLQ SMQ ILQ IMQ ❒ R ❒ L Skin changes SLQ SMQ ILQ IMQ

❒ R ❒ L Nipple changes (❒ Color ❒ Texture) ❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear – S M)

Consent to Infrared Imaging / Thermography

Patient's Name:_____ Date:_____

Address:_____ City:_____

Province:_____ Postal code:_____ Phone #:_____

Age:_____ Gender:_____

Thermography requested by: ❒ Self ❒ Referring Doctor:_____

Ph#: _____

Instructions: Please read the following carefully and initial your name on the line at the end of each section.

I understand that thermography is a procedure utilizing 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 an abnormal process. Consequently, a normal thermogram does not rule out the presence of significant pathology. All thermography reports are meant to identify heat patterns that suggest potential risk markers only and do not in any way suggest diagnosis and/or treatment. Your thermogram report is meant to be used by your treating doctor as an adjunctive aid in the assessment of your health. The report is not to be used for self diagnosis and/or treatment. _____

I understand that infrared imaging of the breast is not intended as a replacement for or alternative to mammography, ultrasound, MRI or any other form of imaging. Thermography is not a stand-alone screening tool, meaning that it is not to be used by itself for screening. _____

I understand that infrared imaging of the breasts and mammography do not provide the same information on breast tissues; and therefore, provide different values on breast tissue assessment (thermography looking for physiological changes and mammography looking for anatomical changes). _____

I understand that the doctor and/or technician providing the infrared imaging, and the doctor interpreting the images, are not diagnosing and/or treating breast abnormalities. Follow up care relating to treatment must be done by properly trained and licensed health care specialists. _____

I understand that if, by any chance, a questionable thermal finding is discovered on my thermogram, I will comply with any and all follow-up or referral recommendations made on my report; such as following up with an ultrasound / mammogram / MRI / etc. or with my primary care doctor to ensure I receive proper care. _____

I understand that I will be disrobed from the waist up for breast exams and buttocks exposed for lower body exams. I will then be imaged with an infrared camera. I understand that this procedure does not use radiation, is not harmful to me, the equipment does not touch my body, and that its sole function is to produce an image of the heat coming off my body. ____

I understand that thermography reports do not in any way suggest diagnosis and/or treatment. No surgical procedure should be based on thermal imaging alone. Additional procedures, which depend on the nature of the condition and/or body region, are needed to achieve a final diagnosis. _____

I understand that thermography must not be confused with EBT, CT, or MRI full body imaging. These are structural imaging technologies that look for the physical presence of tumors and other structure changes inside the body. Thermography does not provide this type of imaging; and as such, cannot be used to screen for the spread of cancer (metastasis). _____

I understand that the results of my thermograms may be made available to my doctors and others as I so designate for further analysis in the overall evaluation of my health. I have also been given pre-imaging instructions to follow and I acknowledge that I have complied with the preparation protocol prior to the procedure. _____

I understand that the information I have reported on the intake forms, and the resultant report and/or images, will be sent via facsimile and/or electronic mail to personnel involved in the process, and/or my health care provider(s). As such, my private health information has the possibility of being seen by unauthorized personnel. Having understood this I give my full consent to having my private health information sent via facsimile and/or email. _____

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 thermography, I hereby consent to both initial and all subsequent infrared imaging.

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

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

Witness:_____ Date:_____