Office Use Only!
Filed ________________________
Mailed ________________________
Payment ______________________

Baseline Report

Name ________________________________ __________D.O. B. ________________

Address_____________________________City_______________St._____Zip_______

Phone____________________________(H) ______________________________(C)

E-mail ___________________________Occupation ___________________________

PLEASE READ THE FOLLOWING AND SIGN BELOW:

BRAS (Breast Research Awareness & Support) uses a Meditherm Digital Infrared Thermal Imaging camera to provide a 15 minute non-invasive test of physiology. DITI detects the minute physiologic changes that accompany breast pathology.

I understand that BRAS does not provide a medical diagnosis, but simply acts as the clinical thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to BRAS. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider. A doctor to doctor consultation can be arranged between Meditherm and your doctor if necessary.

I give my permission for the Clinical Thermographer at BRAS to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that two sets of thermography pictures will be mailed to me so that I can share one with my health care practitioner or primary care doctor.
Doctors name_________________________________.

DATE ____________________
CLIENT SIGNATURE_______________________

DATE____________________

THERMOGRAPHER SIGNATURE__________________________

All Clinical Thermographers are trained and certified by the ACCT.

Patient Name__________________________ DOB _______________________

Be very specific about any breast health surgeries or other breast health problems.

Previous Illnesses –

Previous Surgery-

Current Health Problems-

Medications –

Other Treatments-

Extended Breast Questionnaire

Have you ever been diagnosed with breast cancer? Yes ____No____

Cancer type: Metastic ____ Local ____ Lymph node involvement ____

When diagnosed : Month _____ Year ____

(upper outer, upper inner, lower outer, lower inner)

Where (left breast): UO___UI____LI____LO____

Where (right breast): UO___UI____LI____LO____

Treatment: Surgery____Chemo____Radiation____Other____None____

Diagnosed with breast disease:

Disease type: Fibrocystic____ Cystic____Mastitis____Abscess____Other____

Breast biopsies or surgery:

(upper outer, upper inner, lower outer, lower inner)

Where (left breast): UO___UI____LI____LO____Nipple_____

Where (right breast): UO___UI____LI____LO____Nipple____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Breast Thermography Confidential Questionnaire

	Yes	No
1. Do you have any close relative who has had breast cancer? Who? __________	ڤ	ڤ
2. Have you ever been diagnosed with breast cancer?	ڤ	ڤ
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	ڤ	ڤ
4. Have you had any biopsies or surgeries to your breasts?	ڤ	ڤ
5. Have you had any breast cosmetic surgery or implants?	ڤ	ڤ
6. Have you had a mammogram in the past 12 months?	ڤ	ڤ
7. Have you had a mammogram in the past 5 years?	ڤ	ڤ
8. Have you had abnormal results from any breast testing?	ڤ	ڤ
9. Have you ever taken a contraceptive pill for more than 1 year?	ڤ	ڤ
10. Have you suffered with cancer of the womb?	ڤ	ڤ
11. Have you had pharmaceutical hormone replacement therapy?	ڤ	ڤ
12. Do you have an annual physical examination by a doctor?	ڤ	ڤ
13. Do you perform a monthly breast self exam?	ڤ	ڤ

14. How many mammograms have you had in total? __________

15. What was your age when you had your first mammogram? _________

16. How many births have you had?______Your age at birth of first child._____

17. Did your periods start before the age of 12?______ Or finish after the age of 50? ________

18. Do you smoke? Yes: ڤ Never: ڤ Not in last 12 months: ڤ Not in last 5 years: ڤ

Have you recently had any of these breast symptoms?	**Right Breast**	**Left Breast**
Pain	ڤ	ڤ
Tenderness	ڤ	ڤ
Lumps	ڤ	ڤ
Change in breast size	ڤ	ڤ
Areas of skin thickening or dimpling	ڤ	ڤ
Secretions of the nipple	ڤ	ڤ

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition 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 statements above and consent to the examination.

Signature ……………………………………………………………. Today's date ___________________

Authorization to Use or Disclose Protected Health Information

BRAS, LLC

Patient Name:____

Address: ____

Date of Birth: ______________________ Date of Request:________________

As required by the Privacy Regulations, *BRAS, LLC* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

____

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____ ______________
Signature or Patient or Patient's Authorized Representative Date

____ ______________
Authorized Signature of Facility *Date*