



<b>PATIENT ID:</b> <b>REPORT NO:</b> <b>DATE:</b> <b>PRICE OF SCAN: £</b>
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## THERMAL IMAGING REGISTRATION

### PERSONAL DETAILS

First appointment date: \_\_\_ / \_\_\_ / \_\_\_

Surname:	Forenames:
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Title: Mr /Mrs /Ms /Miss/Other

Date of birth: \_\_\_ / \_\_\_ / \_\_\_

Age:

Address:	
	Postcode:
Telephone (H):	(Mobile)
E-mail:	

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Are you a patient of Dr Daya?

In the past  Currently  In the future (*I have made an appointment*)  No

### What is your preferred form of contact for reminders and messages? *(please tick)*

By letter  By email  (*address*) \_\_\_\_\_

\*By landline  \*By mobile  \*Do you give us permission to leave a full message on this number (*stating the clinic name and a brief message on why we are calling you*)?

Yes

No

### **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.*

- *I would like a copy of my report to be sent to my referring practitioner. YES/NO*
- *I understand that it is my own responsibility as the patient to choose whether to accept any treatment or test options professionally offered.*

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

Signature \_\_\_\_\_

Today's date \_\_\_\_\_

<b>PATIENT ID:</b>
<b>DATE:</b>

### Region of Interest Questionnaire

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.

<b>Name:</b>	<b>D.O.B:</b>
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Please Show areas of :

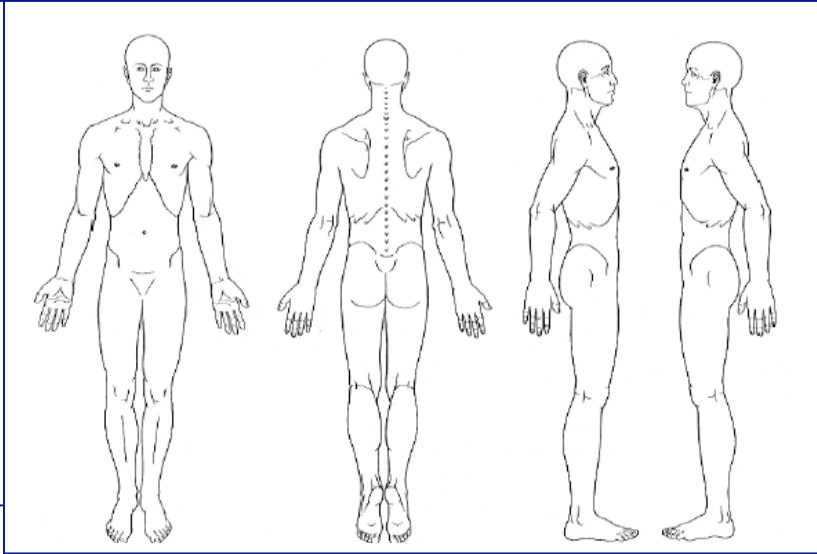
Main Pain \*

Secondary Pain ○

Numbness //////////////

Pins and needles :::::::

Skin lesions / scaring →



- Do you know what triggered the pain ?
- Does anything relieve it ?
- Does anything aggravate it ?
- Has it changed since it began ?
- Have you had any treatment ?

History: Injuries / Fractures / Surgery
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We sometimes use test results from our patients in our research programme and when we do, this is in a completely anonymous way. It helps us make treatment advances in the work we are doing. Do you object to the anonymous use of your tests results for research purposes?

No, I do not object       Yes, I do object

Signed: \_\_\_\_\_ Date: \_\_\_\_\_