



Thermographic Diagnostic Imaging

PHILIP GETSON, DO • BOARD CERTIFIED THERMOLOGIST

100 BRICK ROAD • SUITE 206 • MARLTON, NJ 08503

PHONE: (856) 596-5834 • FAX: (609) 268-5763

WHAT TO DO BEFORE YOUR SCAN: THYROID/FACIAL

PURPOSE OF TEST:

To help determine the physiological abnormalities in the region of the face and neck.

PATIENT PREPARATION:

Please read the attached information carefully. Complete all paperwork prior to your arrival. Please print legibly. All information is confidential and is used by the physician to evaluate your thermal images.

No yoga, massage, sauna or strenuous exercise for at least 3 hours before your scheduled appointment.

Avoid excessively hot or cold liquids one half hour before exam.

Avoid smoking for 2 hours before the exam.

Avoid using lotions or powder on the day of exam and avoid application of deodorant if possible.

Avoid shaving on day of exam to avoid skin abrasion.

Avoid sun exposure for extended periods of time 2 days before and on day of exam.

Please provide a list of medications and supplements either prior to or on the day of exam.

Notify the technician if you are taking Beta Blockers as a medication.

You will need to acclimate to room temperature for 10 minutes prior to your scan. The procedure will take approximately 10 minutes.

Complete testing requires your cooperation to image all areas affected.

TEST RESULTS:

Once your scan is complete it will take approximately 2 weeks before your results will be available. We will mail you a copy of the images and report.

Infrared imaging provide additional information about the studied areas. Like all procedures it is not a 100% guarantee of detection. Ask your health care provider for additional information.

Patient Signature _____ Date: _____ Tech Initial: _____

Date: _____



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Release for Testing Procedure

Infrared imaging is a non-contact, non-invasive test that demonstrates physiological patterns of your body. It is not a stand-alone diagnostic test. The information provided by your thermal scan is combined with your history to enable your health care provider to plan an approach to your care.

A licensed medical practitioner is the only qualified person to formulate a diagnosis. He or she must combine thermographic studies with your additional clinical and testing information to determine your problem. Infrared scans provide evidence of thermal asymmetry. An asymmetry may be indicative of a vascular, neurological, muscular or other physiological problem.

I have read the above information and I understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that a thermal scan is non-invasive and is reading the thermal patterns on the surface of my body. From this information a qualified practitioner will interpret any thermal abnormality displayed.

I am aware that my insurance provider may not reimburse me for the cost of this test. I understand that I am required to pay for this exam at the time of testing.

Print and sign your legal name:

Date: _____

Signature of scanning technician: _____

Date: _____

RECORD RELEASE

I (signature) _____ authorize TDI to release information regarding my scans or to send copies of my scans to the following physicians: (You must provide doctors' names, addresses and phone numbers.)



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THYROID QUESTIONNAIRE

Name: _____ D.O.B: ___ / ___ / ___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-Mail _____

MEDICATIONS AND SUPPLEMENTS: List all you are taking: _____

RELEVANT HISTORY OF PROBLEM:

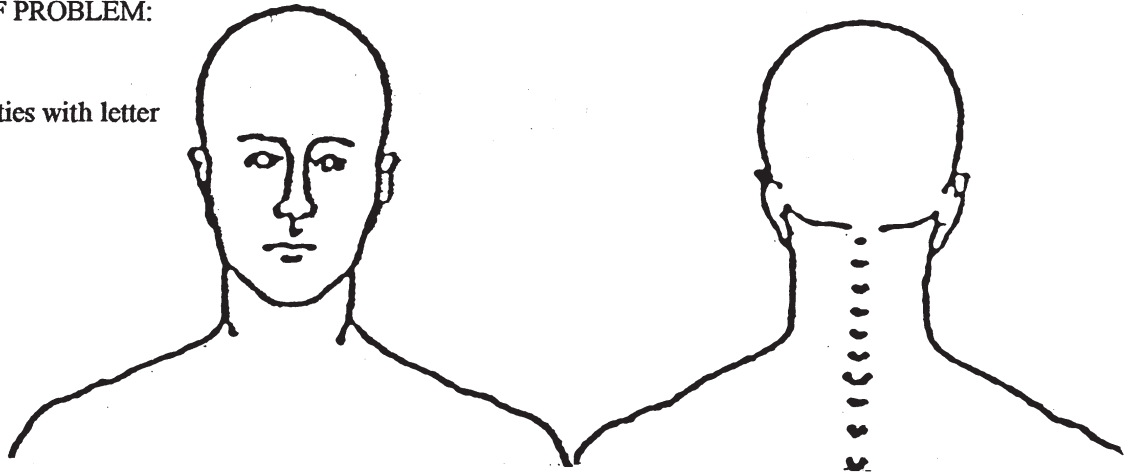
Please designate abnormalities with letter

Pain (if present) (X)

Numbness (N)

Pins and Needles (P)

Skin Lesions (S)



NOTES: _____

PATIENT DISCLAIMER

I acknowledge that I have included all information to the best of my knowledge and consent to the examination.

Patient's Name _____

Technician Initial: _____

Signed: _____

Date: _____

Date: _____

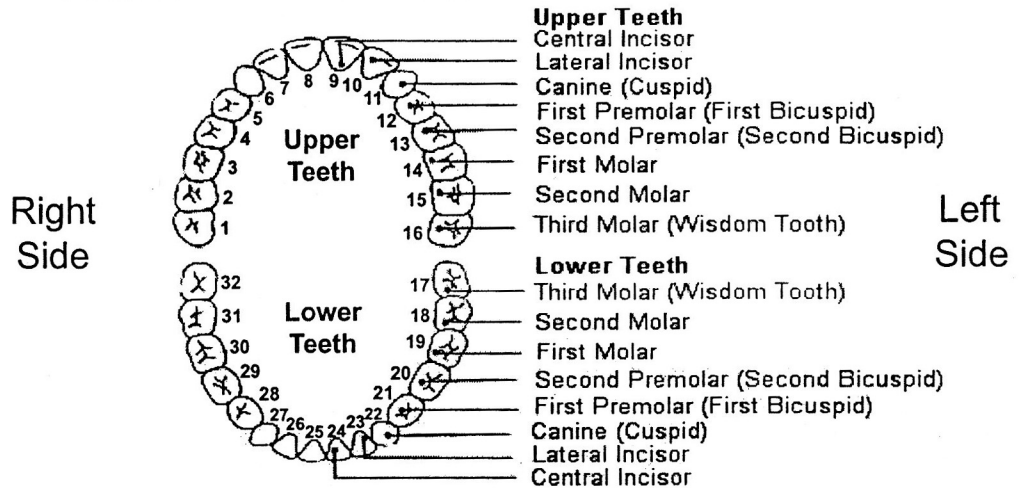
Room Temp _____

Dental History Chart

Name: _____

Date: _____

Tooth Reference Chart



Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example Chart on back.**

Please use the following descriptors when filling in the chart:

- | | | | |
|--|-------------------------|--|---|
| ◆ Silver filling | ◆ Stainless steel crown | ◆ Bridge (circle teeth with bridge attached) | ◆ Full denture |
| ◆ Composite filling (plastic-like filling) | ◆ Root canal | ◆ Partial denture | ◆ Extracted tooth (write next to X'd out tooth) |
| ◆ Gold crown | ◆ Veneers | ◆ No filling | |

Gum Concerns: please make a line at the base of any teeth that have gum problems and indicate what type of concern, such as deep pockets, receding gums, bleeding gums, etc.

