TDI

THERMOGRAPHIC DIAGNOSTIC IMAGING
PHILIP GETSON, D.O. • BOARD CERTIFIED THERMOLOGIST
GARDEN STATE COMMUNITY MEDICAL CENTER
100 BRICK ROAD • SUITE 206 • MARLTON, NJ 08053
(856) 596-5834 • (609) 268-5763

WHAT TO DO BEFORE YOUR SCAN: NEUROMUSCULAR PAIN

PURPOSE OF TEST:
To help determine the physiological response to pain and assist in determining its etiology.

PATIENT PREPARATION:
Complete all paperwork prior to your arrival. If this is not possible, arrive 15 minutes early for your appointment and complete the necessary paperwork at that time. If you have questions call the office. **Please print legibly**. All information is confidential and is used by the physician to evaluate your thermal images.

- The technician will discuss any questions and concerns about any aspect of the examination.
- The technician will refer specific treatment or prognostic questions to the patient's attending physician.
- No yoga, massage, sauna, strenuous exercise, or physical therapy the day of your scheduled appointment.
- No physical stimulation or treatment of the body the day of the exam (no chiropractic, acupuncture, TENS, physical therapy, electrical muscle stimulation, ultrasound, massage, or ice or heat use). Please notify us at the time of scheduling if you have a spinal cord stimulator.
- No caffeine 2 hours before the exam.
- No smoking for 2 hours before the exam.
- No bathing or showering closer than 1 hour before the examination.
- No use of lotions or powder on the day of the exam.
- No shaving on the day of the exam to avoid skin abrasion.
- Avoid sun exposure for extended periods of time 2 days before and on the day of exam – if sunburned please reschedule.
- Please do not wear any jewelry.
- Individuals with long hair or hair that covers the neck, please pull up and off the neck to allow for proper imaging.
- Continue to take all prescribed medications but provide a list of such medications and supplements to the technician at the time of the exam. Specifically notify the technician if beta blockers are being taken as a medication.

You will need to disrobe and remove any splints, braces, etc. (if applicable) and acclimate to room temperature for 10 minutes prior to your scan. The procedure will take approximately 30 minutes. Men should wear or bring an athletic supporter or small briefs; women, bikini briefs or thong. Imaging the buttocks is necessary for a comprehensive study.

If you are disabled or unable to sit or stand for approximately 20 minutes, notify the scheduling technician. Complete testing requires your cooperation to image all areas affected. Nerve pathways travel from your spine to all limbs.

TEST RESULTS:

Once your scan is complete it will take up to 2 weeks before your results will be available by mail. When you receive the images and report, please call the office to schedule a phone conference to discuss the findings.

Infrared imaging increases the chance of detecting nerve, vascular and/or muscular problems.

Patient Signature_____ Tech Initial:_____

Date:_____ Date:_____

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Release for Testing Procedure

Infrared imaging provides information regarding the physiology of the studied areas. It should be used as an adjunct to history, physical exam, laboratory tests, and anatomic imaging studies to arrive at a diagnosis and help formulate a treatment plan.

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 any physiologic problem that may exist. Infrared scans provide evidence of thermal asymmetry. An asymmetry may be indicative of breast disease or of a vascular, neurological, muscular, inflammatory 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 medical practitioner will interpret any thermal abnormality displayed.

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

Print and sign your legal name:

Date:

Signature of scanning technician:

Date:

RECORD RELEASE

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

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NEUROMUSCULAR QUESTIONNAIRE

Name: _____ DOB: ____/____/_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

How were you referred? _____

MEDICATIONS: List all you are taking:_____

_____

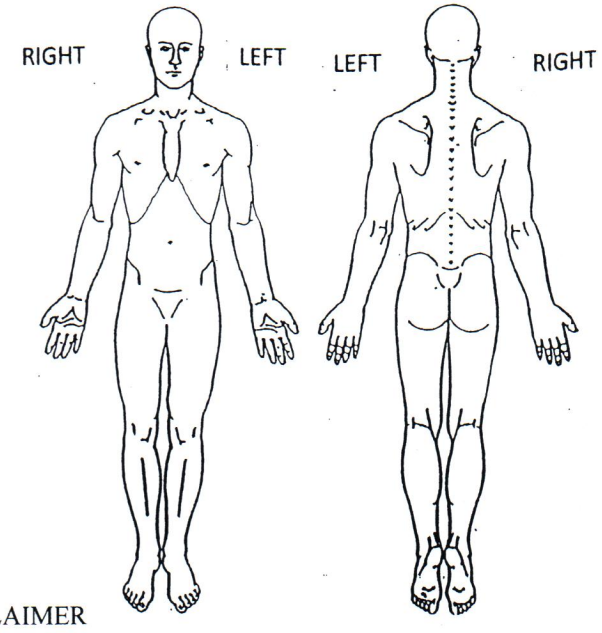
_____

SUPPLEMENTS: List all you are taking: _____

_____

_____

RELEVANT HISTORY OF PROBLEM:



Designate findings with corresponding letter:

Burning	A	Numb	H
Stinging	B	Anesthesia	I
Sharp	C	Heavy	J
Ache	D	Cold	K
Tingling	E	Itching	L
Tender	F	Pins/Needles	M
Dull	G	Skin Lesions & Scarring	N

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: _____

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NEUROMUSCULAR QUESTIONNAIRE - PAGE 2

Other Exams:

EMG: Yes ____ No ____ Date_____ Myelogram: Yes ____ No ____ Date_____

CAT scan: Yes ____ No ____ Date_____ MRI: Yes ____ No ____ Date_____

X-Ray: Yes ____ No ____ Date_____ Other: Yes ____ No ____ Date_____

Findings From Tests (Explain)_____

_____

_____

_____

_____

_____

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:_____