



Thermography Referral Form

Patient Name: _____

Date of Birth: _____ Phone: _____

Referring Provider: _____

Contact Info: Phone _____ Fax _____

Special Instructions:

Please include any pertinent notes or information with referral form

Type of Thermography Imaging

- Breasts**-Thermal Imaging of Both Breasts (anterior, lateral, and oblique views)
 - Women's Health Screening**- Thermal Imaging of Breast, Head (including temporal arteries, dental, and jaw/TMJ screening), neck (including thyroid, carotid arteries, cervical lymph chain), posterior neck, and upper back, abdomen, mid-back (thoracic) and low back (lumbar)
 - Men's Health Screening**- Thermal Imaging of head (including dental, temporal arteries, jaw/TMJ screen), neck (including thyroid, carotid arteries, cervical lymph chain), posterior neck, upper back and anterior chest, abdomen, mid-back and low-back.
 - Full Body**-Includes all imaging the Health Screening, as well as hands, legs, and feet.
 - Region of Interest**-Thermographic imaging of 1 region:
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Provider Signature: _____ Date: _____

Please Sign and Fax to 1 (888)

Please Call I C Health & Beyond at (973) 307-6450 with any questions and thank you for your referral!