True Medical Imaging

10413-67 Avenue, Grande Prairie, AB T8W 0K8

Phone: 780-532-9101 | Fax: 780-833-9118

info@tmigp.com | www.tmigp.com

PATIENT LAST NAME (LEGAL)	PATIENT FIRST NAME (LEGAL)

PREFERRED NAME Last First	DATE OF BIRTH (DD-MON-YYYY)

ULI	ADMINISTRATIVE GENDER Male Female Non-binary / Prefer not to disclose (X)

PATIENT PHONE (CELL PREFERRED)	PATIENT ADDRESS

CITY	POSTAL CODE	WCB CLAIM NUMBER

REFERRING PHYSICIAN NAME	REFERRER CLINIC

REFERRER FAX	REFERRER PHONE	PRACTITIONER ID

REFERRER CITY	REFERRER POSTAL CODE	LOCUM No Yes Primary Referrer:

SIGNATURE	DATE (DD-MON-YYYY)	COPY TO REFERRER (LAST, FIRST)	COPY TO FAX

Requested Procedure — MRI / CT Exam Selection

MRI		CT	
Head	Prostate	Head	Abdomen
Spine	Abdomen	Neck	Pelvis
Joint	Breast	Chest	Spine
Pelvis	MRA	Cardiac / CTA	Other

SPECIFIC REQUESTED PROCEDURE / REGION / LATERALITY

REASON FOR EXAM

CLINICAL QUESTION TO BE ANSWERED

Mandatory Safety Screening: Please review and complete this section with the patient before scheduling an MRI exam.

Screening Item	No	Yes	If Yes:
Pregnant n/a			Date of LMP:
Pediatric / Special Needs			Requires sedation: No Yes Anesthesia
Claustrophobic			Sedation: Oral I.V.
Cardiac pacemaker / defibrillator			
Cochlear Implant			
Deep Brain Stimulator			
Metallic vascular clips (aneurysm clips)			
Metallic foreign body / implants			Specify:
On Dialysis			
Diabetes			Glucose Sensor: No Yes
Mechanical lift / transfer required			Specify:
Previous surgeries			Date: Area: Date: Area: Date: Area:

RECENT GFR	WEIGHT kg lbs	HEIGHT cm in

ALL fields must be completed in order to process request. This form does not save data externally. Version 1. Form 016. Effective Date: May 2026 Review Date: May 2030