



2690 Garnet Ave, San Diego,  
CA 92109  
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Phone: (760)-607-0281

Patient Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

MRI Request

- Cervical Spine       Thoracic Spine       Lumbar Spine
- Elbow (Right / Left)       Knee (Right / Left)       Ankle (Right / Left)
- Shoulder (Right / Left)       Wrist (Right / Left)       Head (DTI)
- Other: \_\_\_\_\_

Attorney/Adjuster Information

Name / Firm: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

