

Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: ANGELA
Last Name: MONTGOMERY
Main Phone: 9739401851
Ext.: 241
Fax: 908 757 5678
Email Address AMONTGOMERY@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: JAMES
Last Name: VITOLLO
Claim Number: IWC087340
Date of Injury: 2024-03-12
ICD Code
Describe Injury: INJ L SHOULDER WHILE WORKING A STRUCTURE FIRE
Working: NO
Occupation: FIRE FIGHTER
Date of Birth: 1980-11-01
Gender: MALE
Home Phone: (732)200-5637
Cell Phone: (973)908-5696
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 148 MOUNTAINVIEW RD.
Address 2:
City: WARREN
State: NJ
Zip: 07059
Preferred Language:

Employee

Company: IRVINGTON TWP
Phone Number: 6102834375

Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work? UNKNOWN

Referring Doctor

First Name: DAVID
Last Name: KLEIN
Practice Name: TRI-COUNTY ORTHO
Phone Number: 973-538-2334
Email Address:
Fax: 908-470-0001
Address 1: 197 RIDGEDALE AVE
Address 2:
City: CEDAR KNOLLS
State: NJ
Zip: 07927
Did patient have surgery?
Surgery Date: 2024-06-06
DX: S/P LEFT SHOULDER DIAGNOSTIC ARTHROSCOPY, OPEN BICEPS TE
Body Parts: RT. SHOULDER
of Auth visits: 36
Freq/Duration: 3X/WK X 12WKS
Script: YES
Follow-up MD: 2024-08-06

Special Instructions

Special Instructions: BELONGS TO CAROLINA.