

# Referral

## Submitter

**Company Name:** D&H ALTERNATIVE RISK SOULUTIONS  
**First Name:** KRISTIN  
**Last Name:** WILKINSON  
**Main Phone:** 973-940-1851  
**Ext.:**  
**Fax:** 973-940-1852  
**Email Address** KWILKINSON@RISKSOLUTIONS.COM

## Claimant

**Request:** PT  
**First Name:** LESLIE  
**Last Name:** CUMMINGS  
**Claim Number:** PJWC084899  
**Date of Injury:** 2023-08-16  
**ICD Code**  
**Describe Injury:** LEFT SHOULDER STRAIN  
**Working:** YES  
**Occupation:** LABORER - DPW  
**Date of Birth:** 1976-11-11  
**Gender:** MALE  
**Home Phone:** 908-532-7320  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 216 EAST 8TH AVE  
**Address 2:**  
**City:** ROSELLE  
**State:** NJ  
**Zip:** 07203  
**Preferred Language:**

## Employee

**Company:** BOROUGH OF ROSELLE  
**Phone Number:** 908-241-2014

**Contact:** KHEESHA WALLS  
**Address 1:** 210 CHESNUT STREET  
**Address 2:**  
**City:** ROSELLE  
**State:** NJ  
**Zip:** 07203  
**PT - Schedule during work hours?** YES  
**What hours does patient work?** 630AM - 230PM (M-F)

## Referring Doctor

**First Name:** GREGORY S.  
**Last Name:** GALLICK, MD  
**Practice Name:**  
**Phone Number:** 908-686-6665  
**Email Address:**  
**Fax:** 908-687-7507  
**Address 1:** 2780 MORRIS AVE  
**Address 2:** 2C  
**City:** UNION  
**State:** NJ  
**Zip:** 07083  
**Did patient have surgery?** NO  
**Surgery Date:**  
**DX:**  
**Body Parts:** LEFT SHOULDER  
**# of Auth visits:** 6  
**Freq/Duration:** 3XS A WK FOR 2 WKS  
**Script:** YES  
**Follow-up MD:** 2023-09-11

## Special Instructions

**Special Instructions:** ANY QUESTIONS PLEASE CONTACT  
KWILKINSON@RISKSOLUTIONS.COM

THANK YOU