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: KIRBY
Last Name: JOHNSTON
Claim Number: MT078771
Date of Injury:
ICD Code
Describe Injury: PAIN IN LEFT SHOULDER

Working: YES
Occupation: SANITATION
Date of Birth: 0025-02-14
Gender: MALE
Home Phone: 908-938-9099
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1:
Address 2: 5 BURNHAM PARKWAY
City: MORRISTOWN
State: NJ
Zip: 07960
Preferred Language:

Employee

Company: TOWN OF MORRISTOWN
Phone Number: 973-292-6672

Contact: CATILIN POSTHUMUS
Address 1: 200 SOUTH ST
Address 2: PO BOX 914
City: MORRISTOWN
State: NJ
Zip: 07960
PT - Schedule during work hours? YES
What hours does patient work? 7AM-330PM (M-F)

Referring Doctor

First Name: ADAM D.
Last Name: BERNSTEIN, MD
Practice Name: GARDEN STATE OTHOPAEDIC ASSOCIATES, P.A
Phone Number: 201-475-0019
Email Address:
Fax: 201-475-8740
Address 1: 28-04 BROADWAY
Address 2:
City: FAIR LAWN
State NJ
Zip: 07410
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts: LEFT SHOULDER
# of Auth visits: 12
Freq/Duration: 3XS A WEEK FOR 4 WEEKS
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE CONTACT LWINTER@RISKSOLUTIONS.COM

PROVIDER?S EDGE ? TWIN BORO - MORRISTOWN

THANK YOU!

NO FOLLOW UP AS OF NOW