

# Referral

## Submitter

**Company Name:** DH ALTERNATIVE RISK SOLUTIONS  
**First Name:** KRISTIN  
**Last Name:** WILKINSON  
**Main Phone:** 9739401851  
**Ext.:**  
**Fax:** 973-940-1852  
**Email Address** KWILKINSON@RISKSOLUTIONS.COM

## Claimant

**Request:** PT  
**First Name:** JOSE  
**Last Name:** TORRES  
**Claim Number:** PJWC086039  
**Date of Injury:** 2023-11-16  
**ICD Code** S49.92XA  
**Describe Injury:** UNSP INJURY OF LEFT SHOULDER AND UPPER ARN. INT  
ENCNTR

**Working:** YES  
**Occupation:** MECHANIC  
**Date of Birth:** 1980-11-25  
**Gender:** MALE  
**Home Phone:** 732-397-5067  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 76 JOHN STREET  
**Address 2:**  
**City:** CARTERET  
**State:** NJ  
**Zip:** 07008  
**Preferred Language:**

## Employee

**Company:** CITY OF PERTH AMBOY

**Phone Number:** 732-826-0290  
**Contact:** MARIA RIVERA  
**Address 1:** 260 HIGH STREET  
**Address 2:**  
**City:** PERTH AMBOY  
**State:** NJ  
**Zip:** 08861  
**PT - Schedule during work hours?** YES  
**What hours does patient work?** 730AM - 330PM (M-F)

## Referring Doctor

**First Name:** SHANTHI  
**Last Name:** REDDY MD  
**Practice Name:** CONCENTRA MEDICAL CENTER NJ  
**Phone Number:** 732-248-0088  
**Email Address:** KWILKINSON@RISKSOLUTIONS.COM  
**Fax:** 732-248-4408  
**Address 1:** 16 ETHEL ROAD  
**Address 2:**  
**City:** EDISON  
**State:** NJ  
**Zip:** 07860  
**Did patient have surgery?** NO  
**Surgery Date:**  
**DX:**  
**Body Parts:**  
**# of Auth visits:** 6  
**Freq/Duration:** 3XS A WEEK FOR 2 WEEKS  
**Script:** YES  
**Follow-up MD:** 2023-11-28

## Special Instructions

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

PLEASE NOTE CORRECT DOL IS 11/16/2023