

# Referral

## Submitter

**Company Name:** D&H ALTERNATIVE RISK SOLUTIONS  
**First Name:** ANGELA  
**Last Name:** MONTGOMERY  
**Main Phone:** 9739401851  
**Ext.:** 241  
**Fax:** 973-940-1852  
**Email Address** AMONTGOMERY@RISKSOLUTIONS.COM

## Claimant

**Request:** PT  
**First Name:** RICKY  
**Last Name:** CRAWFORD  
**Claim Number:** PVS082120  
**Date of Injury:** 2022-11-28  
**ICD Code**  
**Describe Injury:** INJ R WRIST WENT TO TAKE COVER OFF HUB & FELT PAIN  
**Working:** NO  
**Occupation:** MECHANIC  
**Date of Birth:** 1984-07-20  
**Gender:**  
**Home Phone:** 973-356-2042  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 94 ORCHARD STREET  
**Address 2:**  
**City:** GARFIELD  
**State:** NJ  
**Zip:** 07026  
**Preferred Language:**

## Employee

**Company:** PASSAIC VALLEY SEWERAGE COMMISSION  
**Phone Number:** 973-817-5695

**Contact:** CHRISTINE CATENARO  
**Address 1:** 600 WILSON AVENUE  
**Address 2:**  
**City:** NEWARK  
**State:** NJ  
**Zip:** 07105  
**PT - Schedule during work hours?** NO  
**What hours does patient work?** 7A TO 3:30P

## Referring Doctor

**First Name:** LONG  
**Last Name:** BUI-LE  
**Practice Name:** GARDEN STATE ORTHO  
**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?** YES  
**Surgery Date:** 2023-04-04  
**DX:** TFCC DEBRIDEMENT  
**Body Parts:** RT. WRIST  
**# of Auth visits:** 12  
**Freq/Duration:** 3X/WK X 4WKS  
**Script:** YES  
**Follow-up MD:** 2023-05-15

## Special Instructions

**Special Instructions:** BELONGS TO CAROLINA