

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, OT
First Name: MICHAEL
Last Name: GWIZDZ
Claim Number: HST083711
Date of Injury: 0023-04-29
ICD Code S93.492A
Describe Injury: SPRAIN OF OTHER LIGAMANR OF LEFT ANKLE, INITAL
ENCOUNTER

Working: NO
Occupation: FIRE FIGHTER
Date of Birth: 1977-11-26
Gender: MALE
Home Phone: 908-358-5374
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 234 OKLAHOMA DRIVE
Address 2:
City: BRICK
State: NJ
Zip: 08723
Preferred Language:

Employee

Company: HILSIDE TOWNSHIP

Phone Number: 973-926-3002
Contact: DIONNE WADE
Address 1: 1409 LIBERTY AVE
Address 2:
City: HILLSIDE
State: NJ
Zip: 07205
PT - Schedule during work hours? YES
What hours does patient work? 24ON 72 OFF 7:30A TO 7:30A

Referring Doctor

First Name: DR. SHANE M.
Last Name: HOLLAWELL
Practice Name: ORTHOPAEDIC INSTITUTE BRIELLE
Phone Number: 732-800-9000
Email Address:
Fax: 732-612-1435
Address 1: 2315 ROUTE 34 SOUTH
Address 2:
City: MANASQUAN
State: NJ
Zip: 08736
Did patient have surgery? NO
Surgery Date:
DX:
Body Parts: LEFT ANKLE
of Auth visits: 3XS A WK FOR 4 WKS
Freq/Duration: 12
Script: YES
Follow-up MD: 2023-07-06

Special Instructions

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

THANK YOU!

WORK CONDITIONING IS AUTHORIZED FOR 8 SESSIONS