Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: JESSICA
Last Name: LEMASSON
Main Phone: 973-940-1851
Ext.: 286
Fax: 973-940-1852
Email Address JLEMASSON@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: ALEX
Last Name: DORLEANT
Claim Number: IWC088542-02
Date of Injury: 2024-07-03
ICD Code
Describe Injury: INJ R LEG FELT SHARP PAIN WHEN TAKING THE SUSPECT DOWN TO THE GROUND

Working: YES
Occupation: POLICE
Date of Birth: 1984-09-24
Gender: MALE
Home Phone: (862)224-2211
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 18 BECKER TERRACE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
Preferred Language:

Employee

Company: IRVINGTON TOWNSHIP

Phone Number: 973-399-6600
Contact:
Address 1: 1 CIVIC SQUARE
Address 2:
City: IRVINGTON
State: NJ
Zip: 07111
PT - Schedule during work hours?
What hours does patient work? 11 HOUR SCHEDULE 4 DAYS ON, 4 DAYS OFF

Referring Doctor

First Name: ADAM D.
Last Name: BERNSTEIN, MD
Practice Name: GSOA- FAIR LAWN
Phone Number: 201-791-4434
Email Address:
Fax: 201-791-9377
Address 1: 28-04 BROADWAY
Address 2:
City: FAIRLAWN
State NJ
Zip: 07410-3920
Did patient have surgery?
Surgery Date:
DX: RIGHT QUADRICEP CONTUSION/SPRAIN
Body Parts: RIGHT QUADRICEP
# of Auth visits: 8
Freq/Duration: 2X A WEEK/4 WEEKS
Script: YES
Follow-up MD:

Special Instructions

Special Instructions: NEED 8 VISITS DONE BY 8/08

FOR FURTHER QUESTIONS OR CORRESPONDENCE, PLEASE CONTACT:

CSHELL@RISKSOLUTIONS.COM

THANK YOU