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: MRI
First Name: MAGALIZ
Last Name: GONZALEZ
Claim Number: PJWC085751
Date of Injury: 2023-10-19
ICD Code
Describe Injury: INJ R ARM/SHOULDER WHILE REMOVING BOX FROM TOP FILE CABINET DRAWER

Working: YES
Occupation: OFFICE CLERK
Date of Birth: 1962-01-25
Gender: FEMALE
Home Phone: (732)829-0405
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 5302 BRISTOL STATION CT.
Address 2:
City: CARTERET
State: NJ
Zip: 07008
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY

Phone Number: 973-826-2010
Contact:
Address 1:
Address 2: 260 HIGH STREET
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours?
What hours does patient work? 8AM TO 4:30PM

Referring Doctor

First Name: ANDREW
Last Name: WILLIS
Practice Name: TRI COUNTY ORTHO
Phone Number: 9735382334
Email Address:
Fax: 9732676882
Address 1: 197 RIDGEDALE AVE
Address 2:
City: CEDAR KNOLLS
State NJ
Zip: 07927
Did patient have surgery? YES
Surgery Date: 2024-02-12
DX: PAIN AND WEAKNESS
Body Parts: RT. SHOULDER
# of Auth visits:
Freq/Duration:
Script: YES
Follow-up MD: 2024-09-02

Special Instructions

Special Instructions: BELONGS TO LUCIA