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: OT
First Name: TRACY
Last Name: GUARNERI
Claim Number: PER039506
Date of Injury: 2012-06-26
ICD Code
Describe Injury: LEFT / WRIST HAND

Working: YES
Occupation: UNKNOWN
Date of Birth: 1968-10-16
Gender: FEMALE
Home Phone: 848-459-1129
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 99 ARLINGTON DRIVE
Address 2:
City: FORDS
State: NJ
Zip: 08863
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY -PD
Phone Number: 732-442-4400

Contact: MARIA RIVERA
Address 1: 365 NEW BRUNSWICK AVE
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours? YES
What hours does patient work? UNKNOWN

Referring Doctor

First Name: ROMAN
Last Name: ISAAC. MD
Practice Name: HUDSON PRO ORTHOPAEDICS & SPORTS MEDICINE
Phone Number: 201-308-6622
Email Address: INFO.HUDSONPROORTHO.COM
Fax: 201-308-6623
Address 1: 2333 MORRIS AVE
Address 2: BLDG B, SUITE 107
City: UNION
State NJ
Zip: 07083
Did patient have surgery? YES
Surgery Date: 2019-07-30
DX: L WRIST PROXIAL ROW CARPECTOMY & PIN NEURECTOMY
Body Parts: LEFT WRIST / HAND
# of Auth visits: 18
Freq/Duration: 3XS A WEEK FOR 6 WEEKS
Script: YES
Follow-up MD: 2023-03-01

Special Instructions

Special Instructions: ANY QUESTIONS OR FURTHER CORRESPONDENCE PLEASE CONTACT DFORGIONE@RISKSOLUTIONS.COM

THANK YOU