Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: ANGELA
Last Name: MONTGOMERY
Main Phone: 9739401851
Ext.: 241
Fax: 9739401852
Email Address AMONTGOMERY@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: RICKY
Last Name: CRAWFORD
Claim Number: PVS090210
Date of Injury: 2024-12-23
ICD Code
Describe Injury: INJ R HAND/ WRIST(BENT BACKWARDS) WHEN TAKING OFF LAST STAGE VALVE COVER

Working: YES
Occupation: MAINTENANCE WORKER
Date of Birth: 1984-07-20
Gender: MALE
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: 9738175695
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? 8A TO 4:30PM

Referring Doctor

First Name: ROBERT
Last Name: MUSTILLO
Practice Name: IRONBOUND MEDICAL SERVICES
Phone Number: 9738783990
Email Address:
Fax: 973-878-3991
Address 1: 221 CHESTNUT
Address 2:
City: NEWARK
State NJ
Zip: 07105
Did patient have surgery? NO
Surgery Date:
DX: PAIN/STRAIN
Body Parts: RT. WRIST
# of Auth visits: 6
Freq/Duration: 3X/WK X 2 WKS
Script: YES
Follow-up MD: 2025-01-06

Special Instructions

Special Instructions: BELONG TO CAROLINA