

# Referral

## Submitter

**Company Name:** D&H ALTERNATIVE RISK SOLUTIONS  
**First Name:** ANGELA  
**Last Name:** MONTGOMERY  
**Main Phone:** 9739401850  
**Ext.:** 241  
**Fax:** 973-940-1852  
**Email Address** AMONTGOMERY@RISKSOLUTIONS.COM

## Claimant

**Request:** CT  
**First Name:** WILLIAM  
**Last Name:** THOMPSON  
**Claim Number:** TEA042956  
**Date of Injury:** 2013-07-17  
**ICD Code**  
**Describe Injury:** EMPLOYEE INJURED RIGHT SHOULDER WHEN CARRYING  
PATIENT DOWN IN STAIR CHAIR  
  
**Working:** YES  
**Occupation:** FIRE FIGHTER  
**Date of Birth:** 1960-03-24  
**Gender:** MALE  
**Home Phone:** (201)843-5650  
**Cell Phone:** (201) 233-0769  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 65 WEST MAGNOLIA AVENEU  
**Address 2:**  
**City:** MAYWOOD  
**State:** NJ  
**Zip:** 07607  
**Preferred Language:**

## Employee

**Company:** TEANECK TWP

**Phone Number:** 201-837-4816  
**Contact:** MARION SHUMPERT  
**Address 1:** MUNICIPAL BLDG  
**Address 2:**  
**City:** TEANECK  
**State:** NJ  
**Zip:** 07666  
**PT - Schedule during work hours?**  
**What hours does patient work?** 8A TO 8A

## Referring Doctor

**First Name:** KASSANDRA  
**Last Name:** KAYAL  
**Practice Name:** ORTHO EAST  
**Phone Number:** 973-686-0700  
**Email Address:**  
**Fax:** 973-686-0701  
**Address 1:** 504 VALLEY ROAD  
**Address 2:**  
**City:** WAYNE  
**State:** NJ  
**Zip:** 07470  
**Did patient have surgery?**  
**Surgery Date:**  
**DX:** DEGENERATIVE DISC DISEASE, CERVICAL. CERVICAL RADICULOPATHY  
**Body Parts:** CERVICAL  
**# of Auth visits:**  
**Freq/Duration:**  
**Script:** YES  
**Follow-up MD:** 2017-11-20

## Special Instructions

**Special Instructions:** BELONGS TO LUCIA