

# Referral

## Submitter

**Company Name:** D&H ALTERNATIVE RISK SOLUTIONS  
**First Name:** JESSICA  
**Last Name:** LEMASSON  
**Main Phone:** 9739401851  
**Ext.:**  
**Fax:** 9739401852  
**Email Address** JLEMASSON@RISKSOLUTIONS.COM

## Claimant

**Request:** PT  
**First Name:** ERIC  
**Last Name:** TEMPLE  
**Claim Number:** GSCR085953  
**Date of Injury:** 2023-11-13  
**ICD Code** 845, S93.402A  
**Describe Injury:** SPRAIN OF UNSPECIFIED LIGAMENT OF LEFT ANKLE,  
**Working:** YES  
**Occupation:** LABORER  
**Date of Birth:** 1981-03-03  
**Gender:** MALE  
**Home Phone:** (732)943-8431  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 32 C SEAFOAM AVE.  
**Address 2:**  
**City:** WINFIELD  
**State:** NJ  
**Zip:** 07036  
**Preferred Language:**

## Employee

**Company:** CITY OF RAHWAY/DPW DOT  
**Phone Number:** (732) 827-2177

**Contact:** MICHELLE DALESANDRIS  
**Address 1:** 1 CITY HALL PLAZA  
**Address 2:**  
**City:** RAHWAY  
**State:** NJ  
**Zip:** 07065  
**PT - Schedule during work hours?** YES  
**What hours does patient work?** 6:00 AM-1:15 PM, M-F

## Referring Doctor

**First Name:** GENEVIEVE  
**Last Name:** NWIGWE, MD  
**Practice Name:** CONCENTRA MEDICAL CENTERS (NJ)  
**Phone Number:** (732) 381-3636  
**Email Address:**  
**Fax:** (732) 381-5977  
**Address 1:** 2 CITY HALL PLAZA  
**Address 2:** STE 302  
**City:** RAHWAY  
**State:** NJ  
**Zip:** 07065  
**Did patient have surgery?** NO  
**Surgery Date:**  
**DX:** SPRAIN OF UNSPECIFIED LIGAMENT OF LEFT ANKLE,  
**Body Parts:** LEFT ANKLE  
**# of Auth visits:** 6  
**Freq/Duration:** 3X A WEEK FOR 2 WEEKS  
**Script:** YES  
**Follow-up MD:**

## Special Instructions

**Special Instructions:** FOR FURTHER QUESTIONS OR CORRESPONDENCE, PLEASE  
CONTACT:

KWILKINSON@RISKSOLUTIONS.COM

THANK YOU