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: PT
First Name: RAFAEL
Last Name: DIAZ-JOSE
Claim Number: PJWC080706
Date of Injury: 2022-07-28
ICD Code
Describe Injury: LEFT SHOULDER

Working: YES
Occupation: SANITATION
Date of Birth: 1986-03-02
Gender: MALE
Home Phone: 732-664-6418
Cell Phone:
Work Phone:
Ext.:
Alternate Phone:
Alt. Phone Description:
Email Address:
Address 1: 352 STATE STREET
Address 2: PMB 150
City: PERTH AMBOY
State: NJ
Zip: 08661
Preferred Language:

Employee

Company: CITY OF PERTH AMBOY
Phone Number: 732-826-0290

Contact: MARIA RIVERA
Address 1: 260 HIGH STREET
Address 2:
City: PERTH AMBOY
State: NJ
Zip: 08861
PT - Schedule during work hours? YES
What hours does patient work? OOW

Referring Doctor

First Name: MATTHEW
Last Name: GARFINKEL MD
Practice Name: EDISON-METUCHEN ORTHOPAEDIC GROUP
Phone Number: 732-494-6226
Email Address:
Fax: 732-494-8762
Address 1: 10 PARSONAGE ROAD
Address 2: SUITE 500, 5TH FLOOR
City: EDISON
State NJ
Zip: 08837
Did patient have surgery? YES
Surgery Date: 2023-02-24
DX: LT SHLDR ARTHRO W/ACROMIOPLASTY,ROTATOR CUFF/LABRAL RE
Body Parts: LEFT SHOULDER
# of Auth visits: 12
Freq/Duration: 3XS A WEEK FOR 4 WEEKS
Script: YES
Follow-up MD:

Special Instructions

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

THANK YOU