

# 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:** FELIX  
**Last Name:** CHECO  
**Claim Number:** PJWC083152  
**Date of Injury:** 2023-03-13  
**ICD Code** 840.3 & S49.911A  
**Describe Injury:** STRAIN UNSP MUSC/FASC/TEND AT SHLDR/UP ARM, RIGHT ARM, II

**Working:** YES  
**Occupation:** SANITATION  
**Date of Birth:** 1996-12-07  
**Gender:** MALE  
**Home Phone:** 908-380-5593  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 463 STEVENSON PLACE  
**Address 2:**  
**City:** PERTH AMBOY  
**State:** NJ  
**Zip:** 08861  
**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?**  
**What hours does patient work?** 5AM -11AM (M-F)

## Referring Doctor

**First Name:** LUCKNIE  
**Last Name:** QVINCY, PA  
**Practice Name:** CONCENTRA MEDICAL CENTER NJ  
**Phone Number:** 732-248-0088  
**Email Address:**  
**Fax:** 732-248-4408  
**Address 1:** 16 ETHEL ROAD  
**Address 2:**  
**City:** EDISON  
**State:** NJ  
**Zip:** 08817  
**Did patient have surgery?** NO  
**Surgery Date:**  
**DX:**  
**Body Parts:**  
**# of Auth visits:** 6  
**Freq/Duration:** 3XS A WEEK FOR 2 WEEKS  
**Script:** YES  
**Follow-up MD:**

## Special Instructions

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

PLASE SET UP PT IN PERTH AMBOY PT

THANK YOU