Referral

Submitter

Company Name: D&H ALTERNATIVE RISK SOLUTIONS
First Name: ANGELA
Last Name: MONTGOMERY
Main Phone: 9739401851
Ext.: 241
Fax: 973-940-1852
Email Address AMONTGOMERY@RISKSOLUTIONS.COM

Claimant

Request: PT
First Name: RICKY
Last Name: CRAWFORD
Claim Number: PVS082120
Date of Injury: 2022-11-28
ICD Code
Describe Injury: INJ R WRIST WENT TO TAKE COVER OFF HUB & FELT PAIN

Working: YES
Occupation: MECHANIC
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: 973-817-5695

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? 7A TO 3:30P

Referring Doctor

First Name: STEVEN
Last Name: SHAMASH
Practice Name: GARDEN STATE ORTHO
Phone Number: 201-475-0019
Email Address:
Fax: 201-475-8740
Address 1: 925 CLIFTON AVENUE
Address 2:
City: CLIFTON
State NJ
Zip: 07013
Did patient have surgery? NO
Surgery Date:
DX: PAIN
Body Parts: RT. WRIST
# of Auth visits: 6
Freq/Duration: 2X/WK X 3WKS
Script: YES
Follow-up MD: 2023-01-09

Special Instructions

Special Instructions: BELONGS TO CAROLINA