

# Referral

## Submitter

**Company Name:** D&H ALTERNATIVE RISK SOLUTIONS  
**First Name:** JESSICA  
**Last Name:** LEMASSON  
**Main Phone:** 973-940-1851  
**Ext.:** 286  
**Fax:** 973-940-1852  
**Email Address** JLEMASSON@RISKSOLUTIONS.COM

## Claimant

**Request:** PT  
**First Name:** MAGALIZ  
**Last Name:** GONZALEZ  
**Claim Number:** PJWC085751  
**Date of Injury:** 2023-10-19  
**ICD Code**  
**Describe Injury:** RIGHT SHOULDER ARTHROSCOPY AND ACROMIOPLASTY  
**Working:** NO  
**Occupation:** OFFICE CLERK  
**Date of Birth:** 1962-01-25  
**Gender:** FEMALE  
**Home Phone:** (732)829-0405  
**Cell Phone:**  
**Work Phone:**  
**Ext.:**  
**Alternate Phone:**  
**Alt. Phone Description:**  
**Email Address:**  
**Address 1:** 5302 BRISTOL STATION CT  
**Address 2:**  
**City:** CARTERET  
**State:** NJ  
**Zip:** 07008  
**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?** NO  
**What hours does patient work?** OOW

## Referring Doctor

**First Name:** MATTHEW J.  
**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  
**City:** EDISON  
**State:** NJ  
**Zip:** 08837  
**Did patient have surgery?** YES  
**Surgery Date:** 2024-02-12  
**DX:** RIGHT SHOULDER ARTHROSCOPY AND ACROMIOPLASTY  
**Body Parts:** RIGHT SHOULDER  
**# of Auth visits:** 12  
**Freq/Duration:** 3X A WEEK/ 4 WEEKS  
**Script:** YES  
**Follow-up MD:**

## Special Instructions

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

LWINTER@RISKSOLUTIONS.COM

THANK YOU