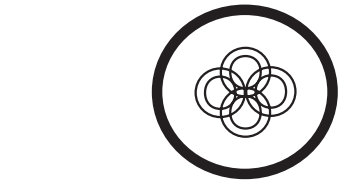

onword THERAPY

P | 701.364.5433
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4450–31st Ave S. Suite 103, Fargo, ND 58104

Order for Outpatient Treatment

Patient Name DOB

◯ Evaluate and Treat ◯ Evaluation Only

Duration

◯ Therapist Discretion or _____times/week?

◯ Cognitive-Communication
◯ Language
◯ Voice
◯ Swallowing

Primary MD

Diagnosis/Reason for Referral

Recent progress notes included ◯ yes ◯ no

Physician Signature Date