

FAMILY ASSISTANCE PROGRAM
**Documentation of Pediatric Feeding Disorder or Feeding Difficulties**

**<Name>**

**<Organization’s Name>**

**<Address>**

**<Phone Number>**

**<Date>**

To whom it may concern:

This is to confirm that **<Patient>** has been seen for a pediatric feeding disorder (PFD) or for feeding difficulties.

I have been treating this patient for <**duration of patient treatment>** and have **<made the following referrals/have made no referrals>**.

**<Name>**

**<Signature and Date>**